(21)

No. 00-1021-CFX Title: Rush Prudential HMO, Inc., Petitioner
v.
Debra C. Moran, et al.

Docketed: December 27, 2000 Court: United States Court of Appeals for the Seventh Circuit

Entry	Date	Proceedings and Orders
	Dec 22 2000	Petition for writ of certiorari filed. (Response due February 25, 2001)
	Jan 11 2001	Order extending time to file response to petition until February 25, 2001.
	Jan 22 2001	Waiver of right of respondent Illinois to respond filed.
	Feb 20 2001	Brief of respondent Debra Moran in opposition filed.
	Feb 26 2001	Motion of National Association of Insurance Commissioners for leave to file a brief as amicus curiae filed.
	Mar 5 2001	Reply brief of petitioner Rush Prudential HMO, Inc. filed.
	Mar 7 2001	DISTRIBUTED for Conference of March 23, 2001
	Mar 26 2001	The Solicitor General is invited to file a brief in this case expressing the views of the United States.
	May 31 2001	Brief amicus curiae of United States filed. VIDED.
	Jun 5 2001	REDISTRIBUTED for Conference of June 21, 2001
	Jun 7 2001	Supplemental brief of petitioner Rush Prudential HMO, Inc. filed.
	Jun 25 2001	REDISTRIBUTED for Conference of June 28, 2001
	Jun 29 2001	Motion of National Association of Insurance Commissioners for leave to file a brief as amicus curiae GRANTED.
	Jun 29 2001	Petition GRANTED. SET FOR ARGUMENT January 16, 2002. **********
	Jul 31 2001	Order extending time to file the joint appendix and petitioner's brief on the merits to and including September10, 2001.
	Sep 10 2001	Brief amici curiae of American Association of Health Plans, Inc., et al. filed.
	Sep 10 2001	Joint appendix filed.
	Sep 10 2001	Brief of petitioner Rush Prudential HMO, Inc. filed.
	Sep 14 2001	Order extending time to file respondents' brief on the merits to and including November 7, 2001.
	Oct 18 2001	Blanket consent to the filing of amicus briefs in support of either party received from counsel for the petitioner and counsel for the respondents.
	Nov 5 2001	Order further extending time for respondent Illinois to file the brief on the merits to and including November 15, 2001.
	Nov 5 2001	Brief amicus curiae of United Policyholders filed.
	Nov 6 2001	Brief amici curiae of Texas, et al. filed.
	Nov 7 2001	Brief amicus curiae of United States filed.
	Nov 7 2001	Brief amici curiae of AARP, et al. filed.
	Nov 7 2001	Brief amici curiae of American Medical Association, et al. filed.
	Nov 7 2001	Brief amicus curiae of National Association of Insurance

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Entry	Date	Proceedings and Orders
		Commissioners filed.
	Nov 7 2001	Brief of respondents Debra Moran, et al. filed.
	Nov 7 2001	Brief amici curiae of Texas Watch and Jacqueline Burross filed.
	Nov 8 2001	CIRCULATED.
	Nov 15 2001	Brief of respondent Illinois filed.
	Nov 15 2001	Brief amici curiae of California Consumer Health Care Council, et al. filed.
	Nov 21 2001	Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument filed.
	Dec 5 2001	Response of United Policyholders as amicus curiae to motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument filed.
	Dec 7 2001	Reply brief of petitioner Rush Prudential HMO, Inc. filed.
	Dec 10 2001	Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument GRANTED.
	Dec 10 2001	Record filed.
	Jan 16 2002	ARGUED.

Supreme Court, U.S.
FILED

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OFFICE OF THE CLERK

No. 00-

IN THE

Supreme Court of the United States

RUSH PRUDENTIAL HMO, INC.,
Petitioner,

v.

DEBRA C. MORAN AND STATE OF ILLINOIS,
Respondents.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

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QUESTION PRESENTED

Section 4-10 of the Illinois Health Maintenance Organization Act provides that, if a patient's primary care physician deems a proposed procedure desired by the patient to be medically necessary, but the HMO disagrees and denies coverage for the procedure, the patient may have the HMO's decision reviewed by an outside physician, and the HMO must abide by the reviewing physician's determination. The Seventh Circuit held in this case that this independent review process was not preempted by the Employee Retirement Income Security Act ("ERISA")—in square conflict with a recent Fifth Circuit decision holding that a materially identical Texas law *was* preempted by ERISA.

The question presented is:

Whether the independent review provision of the Illinois HMO Act, which is similar to laws adopted in 37 states and the District of Columbia, is preempted by ERISA.

RULE 29.6 STATEMENT

Petitioner Rush Prudential HMO, Inc., now known as UNICARE Health Plans of the Midwest, Inc., is wholly owned by UNICARE Health Plans, an Illinois general partnership, which is ultimately owned by Wellpoint Health Networks, Inc., a publicly held company.

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DEBRA C. MORAN AND STATE OF ILLINOIS,
Respondents.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

PETITION FOR A WRIT OF CERTIORARI

Petitioner Rush Prudential HMO, Inc., respectfully petitions this Court for a writ of certiorari to review the judgment of the United States Court of Appeals for the Seventh Circuit in this case.

OPINIONS BELOW

The opinion of the Seventh Circuit, together with the dissent from denial of rehearing en banc, is reported at 230 F.3d 959. The opinion is reproduced in the appendix hereto ("App.") at 1a, and the dissent from denial of rehearing en banc is reproduced at App. 24a. The opinions and orders of the United States District Court for the Northern District of Illinois dated June 9, 1998, March 24, 1999, May 6, 1999, and June 15, 1999, are not reported; they are reproduced at App. 28a, 35a, 44a, and 47a, respectively.

JURISDICTION

The judgment of the Seventh Circuit was entered on October 19, 2000. App. 1a. The jurisdiction of the Seventh Circuit was based on 28 U.S.C. § 1291. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The Supremacy Clause of the United States Constitution provides in pertinent part:

> This Constitution, and the Laws of the United States which shall be made in Pursuance thereof * * * shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding. [U.S. Const., art. VI, cl. 2.]

Section 502(a) of the Employee Retirement Income Security Act of 1974 ("ERISA")—the statute's civil enforcement provision—provides in pertinent part:

> (a) Persons empowered to bring a civil action. A civil action may be brought—(1) by a participant or beneficiary—(A) for the relief provided for in subsection (c) of this section, or (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan * * *. [29 U.S.C. § 1132(a).]

Section 514(a) of ERISA—the preemption provision—provides in pertinent part:

> (a) Supersedure; effective date. Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in

> section 1003(a) of this title and not exempt under section 1003(b) of this title. [29 U.S.C. § 1144(a).]

Section 514(b)(2)(A) of ERISA—the savings clause—provides:

> (b) Construction and application. * * * (2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities. [29 U.S.C. § 1144(b)(2)(A).]

Section 4-10 of the Illinois Health Maintenance Organization Act provides:

> Medical Necessity—Dispute Resolution—Independent Second Opinion. Each Health Maintenance Organization shall provide a mechanism for the timely review by a physician holding the same class of license as the primary care physician, who is unaffiliated with the Health Maintenance Organization, jointly selected by the patient (or the patient's next of kin or legal representative if the patient is unable to act for himself), primary care physician and the Health Maintenance Organization in the event of a dispute between the primary care physician and the Health Maintenance Organization regarding the medical necessity of a covered service proposed by a primary care physician. In the event that the reviewing physician determines the covered service to be medically necessary, the Health Maintenance Organization shall provide the covered service. Future contractual or employment action by the Health Maintenance Organization regarding the primary care physician shall not be based solely on the physician's participation in this procedure. [215 Ill. Comp. Stat. 125/4-10.]

INTRODUCTION

Health Maintenance Organizations, or HMOs, have become a prominent feature of the American health care system. "The defining feature of an HMO is receipt of a fixed fee for each patient enrolled under the terms of a contract to provide specified health care if needed." *Pegram* v. *Herdrich*, 120 S. Ct. 2143, 2149 (2000). HMOs "commonly require utilization review (in which specific treatment decisions are reviewed by a decisionmaker other than the treating physician) and approval in advance (precertification) for many types of care, keyed to standards of medical necessity or the reasonableness of the proposed treatment." *Id.* The rise of the HMO has drawn the attention of state lawmakers, who have increasingly subjected these organizations to additional regulation.

Petitioner Rush Prudential HMO, Inc. ("Rush") is an HMO that provided access to medical and hospital care for a medical benefits plan sponsored by the employer of the husband of respondent Debra C. Moran ("Moran"). The plan is an employee welfare benefit plan subject to the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.* Under the applicable Certificate of Group Coverage ("Certificate"), Rush provides coverage only when it determines services to be "medically necessary," and it exercises "the broadest possible discretion" to make that determination.

At issue in this case is whether ERISA preempts an Illinois statute providing for the binding independent review of an HMO's decision regarding the medical necessity of a proposed procedure. At last count, thirty-seven States and the District of Columbia had enacted such "independent review" or "external appeal" statutes.

The Seventh Circuit held in this case that ERISA does not preempt the Illinois law, and in so doing prompted Judge Posner, joined by three other judges, to dissent from the

denial of rehearing en banc. Judge Posner noted that "[t]his case is well worth the attention of the full court. The panel's decision creates a square conflict with another circuit, is very probably unsound, and will affect an enormous number of cases." App. 24a. He added that "[i]t is also a single issue case, and the issue is one of law, so that en banc consideration would be unlikely to create a fractured result or bog the court down in factual questions. Rarely have we had so strong a candidate for en banc review." *Id.*

The same compelling reasons that made this case a strong candidate for en banc review also make it a front-runner for review by this Court. The decision below directly conflicts with a recent decision of the Fifth Circuit—a fact that the panel below as well as Judge Posner expressly recognized. *See Corporate Health Ins., Inc.* v. *Texas Dep't of Ins.*, 215 F.3d 526 (5th Cir.), *further opinion on pet. for reh'g*, 220 F.3d 641 (5th Cir. 2000), *pet. for cert. filed sub nom., Montemayor* v. *Corporate Health Ins., Inc.*, 69 U.S.L.W. 3317 (Oct. 24, 2000) (No. 00-665).[1] And because over two-thirds of the States have adopted independent review statutes relevantly similar to the Illinois law at issue here and the Texas law at issue in *Corporate Health*, the ERISA preemption questions raised by such statutes are guaranteed to arise again and again. This Court should review the Seventh Circuit's "startling decision," App. 26a (Posner, J.), and resolve the conflict among the circuits on this weighty issue.

STATEMENT OF THE CASE

Facts. Moran sought treatment in 1996 from Dr. Arthur LaMarre, a Rush-affiliated primary care physician, for pain, numbness, loss of function, and decreased mobility in her right shoulder. App. 3a. LaMarre attempted to relieve Moran's symptoms through physiotherapy. *Id.* at 3a-4a.

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[1] This petition has been served on all the parties in *Corporate Health*.

While she was still undergoing this treatment, Moran sought the opinion of Dr. Julia Terzis, an out-of-network surgeon in Virginia. Terzis confirmed the diagnosis of Moran's symptoms as "brachial plexopathy and thoracic outlet syndrome ('TOS'), a nerve compression syndrome caused by the compression of nerves in Ms. Moran's brachial plexis." *Id.* at 4a.

As treatment for Moran's condition, "surgery is not indicated unless more conservative measures"—such as the physiotherapy that LaMarre had already prescribed—"fail to manage the symptoms." *Id.* In the event that surgery is necessary, "the standard procedure for TOS involves decompression by way of first rib resection (the complete removal of the uppermost rib) or first rib resection with scalenectomy (the removal of the rib and the attached muscle)." *Id.* Terzis, however, recommended for Moran a more complicated and rare form of TOS surgery that Terzis herself had developed: "Dr. Terzis' surgery consists of rib resection, extensive scalenectomy, and, if indicated, microneurolysis of the lower roots of the brachial plexus under intraoperative microscopic magnification." *Id.*

Moran asked LaMarre to obtain approval from Rush for this complicated surgery suggested by Terzis. LaMarre sought out the views of two other surgeons, neither of whom recommended the Terzis surgery for Moran. *Id.* at 5a. After Rush declined to approve payment for the treatment because it was not medically necessary, Moran appealed the decision pursuant to the review procedure provided under the benefit plan. Upon further review, Rush affirmed its denial on the ground that the extensive surgery proposed by Terzis was not medically necessary, but advised Moran that it would cover the standard TOS surgery—first rib resection with scalenectomy—performed by a network surgeon. *Id.* An additional appeal to Rush's membership advisory committee upheld Rush's medical necessity decision. *Id.*

Having exhausted the various review procedures provided in the benefit plan without obtaining a favorable ruling on medical necessity, Moran next sought to invoke the additional external review procedure established by Section 4-10 of the Illinois HMO Act, under which a determination by the HMO that a procedure is not medically necessary is reviewed by an independent physician. *See supra* at 3. While Moran's request for independent review was still pending, Moran decided to undergo the microneurolysis surgery. Dr. Terzis performed the 14-hour procedure, which together with post-operative care cost nearly $95,000. After paying for the surgery herself, Moran sought reimbursement from Rush. Rush undertook yet another investigation of the claim, seeking opinions from additional experts. None of the doctors consulted by Rush concluded that Moran's surgery was medically necessary, and Rush declined to reimburse Moran. *Id.* at 6a.

Proceedings Below. This litigation began when Moran filed a complaint in state court seeking, *inter alia*, specific performance of the external review provisions in Section 4-10 of the Illinois law.[2] The state court ordered Rush to permit the review provided for in Section 4-10. That review was conducted by one Dr. Dellon, who "concluded that the surgery was medically necessary," App. 8a, while noting that

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[2] Because the complaint sought to obtain or compel benefits under an ERISA-regulated employee welfare benefit plan and was, in Rush's view, completely preempted by federal law, Rush removed the case to federal court. Moran moved to remand to state court, and the district court granted her motion. The court reasoned that the request for specific performance of the review procedure was not a claim under ERISA's civil enforcement provisions and therefore was not completely preempted. The district court also noted that a claim for reimbursement after the external review had been completed might well be a claim for benefits that is completely preempted by ERISA. *See* App. 33a-34a.

he would have used a less intrusive and less time-consuming procedure. *Id.* After reviewing Dr. Dellon's report and reports from three other physicians, Rush again denied Moran's claim on the ground that the surgery was not medically necessary.

Moran amended her complaint to seek reimbursement for the surgery in the amount of $94,841.27. Rush removed the suit to federal court on the ground that a demand for reimbursement is completely preempted by ERISA and must be brought under Section 502(a) of ERISA, the statute's civil enforcement provision. 29 U.S.C. § 1132(a). Recognizing that the claim was now simply one for benefits, the district court denied Moran's motion to remand.

The district court then determined that Moran's Section 4-10 demand for payment was "preempted by ERISA's civil enforcement policy in § 502(a)." App. 53a. As the court explained: "Regardless of how she characterizes it, Moran's current claim is a § 502(a) denial of benefits claim. Moran asserts her right to have Rush cover the costs of medical treatment pursued outside of her HMO plan. Rush refused to reimburse her for the treatment. Rush's refusal is a determination of benefits within the meaning of ERISA. Accordingly, Moran's claim for reimbursement is preempted by ERISA." App. 41a-42a.

The district court also rejected Moran's effort to escape preemption through the so-called "savings clause," 29 U.S.C. § 1144(b)(2)(A) ("nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance"). Finding that the state law "does not operate to transfer or spread a policyholder's risk" but only "affects * * * particular instances," the district court concluded that Section 4-10 is not a law that "regulates insurance" and that the savings clause therefore did not

rescue the state law from preemption. App. 42a-43a.[3] Analyzing Moran's demand for reimbursement under principles of federal law, the district court entered summary judgment for Rush on the ground that "Rush did not abuse its discretion or act arbitrarily in denying Moran's benefit claim." App. 56a.

The Seventh Circuit reversed. It first determined that removal was proper because "Ms. Moran's state law claims are properly recharacterized as claims for benefits under Section 502(a)(1)(B) of ERISA and, therefore, are completely preempted." App. 13a. The court of appeals also concluded that the state law claims were initially within the reach of ERISA's express preemption provision, found in Section 514(a) of the Act. 29 U.S.C. § 1144(a) (except as provided in subparagraph (b), the provisions of ERISA "shall supersede any and all State laws insofar as they may now or hereafter related to any employee benefit plan"). *See* App. 14a.

The Seventh Circuit then considered whether Section 4-10 regulates insurance and therefore could escape preemption under the savings clause of Section 514(b)(2)(A). The court noted (App. 16a) that, after *Ward*, the determination whether a law regulates insurance first requires examination of "whether, from 'a common-sense view of the matter,' the contested prescription regulates insurance." *Ward*, 526 U.S. at 367 (quoting *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724, 740 (1985)). The court next is directed to

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[3] The district court's initial decision on the savings clause came before this Court's decision in *UNUM Life Insurance Co.* v. *Ward*, 526 U.S. 358 (1999), which clarified the test to be applied for determining when a law "regulates insurance." After *Ward*, Moran sought reconsideration. The district court determined that even if the savings clause applied, an exemption from the clause—the so-called "deemer clause"—once again gave preemptive effect to the federal law. App. 46a (citing 29 U.S.C. § 1144(b)(2)(B)).

consider "three factors employed to determine whether the regulation fits within the 'business of insurance' as that term is used in the McCarran-Ferguson Act." *Ward*, 526 U.S. at 367. These factors are whether the practice (1) has the effect of transferring or spreading a policyholder's risk, (2) is an integral part of the policy relationship between the insurer and the insured, and (3) is limited to entities within the insurance industry. *See* App. 16a-17a.

The Seventh Circuit concluded "that § 4-10 of the HMO Act falls within the saving clause because it 'regulates insurance' under a common sense understanding and because it meets at least two of the McCarran-Ferguson factors"—the second and third factors identified above. App. 17a. The court also determined that the "deemer clause"—under which the preemptive effect of federal law is restored despite the fact that a state law regulates insurance—did not apply in this case. *Id.* at 18a-19a. The employee welfare benefit plan here is not self-funded but rather is an insured plan, and the court of appeals determined that the deemer clause did not apply to such plans. *Id.* at 18a.

The Seventh Circuit then considered whether Section 4-10, despite falling within the savings clause, was nonetheless preempted because it "conflicts with a substantive provision of ERISA." *Id* at 19a. Despite having concluded when considering the propriety of removal that "Ms. Moran's state law claims are properly recharacterized as claims for benefits under § 502(a)(1)(B) of ERISA and, therefore, are completely preempted," App. 13a, the court now found that the provisions of Section 4-10 were *not* preempted by Section 502(a)(1)(B). App. 19a-23a. It reasoned that the provisions of Section 4-10 were incorporated into the plan and that therefore "a suit by [Moran] to enforce the HMO Act's provisions is simply a suit to enforce the terms of the plan—precisely the sort of suit that is contemplated by § 502(a)(1)(B) 'to enforce rights' and 'to recover benefits' under the plan." App. 21a.

The court recognized that its decision conflicted with the Fifth Circuit's decision in *Corporate Health*, "in which the court considered an independent review statute from Texas that is quite similar to § 4-10 of Illinois' HMO Act." App. 19a. The Seventh Circuit disagreed with the Fifth Circuit's conclusion that the state law independent review mechanism created an alternative civil enforcement scheme in addition to and inconsistent with that provided in ERISA itself. It relied instead on its view that Section 4-10 creates an additional term of the plan by operation of law. Thus, it concluded that a suit to enforce rights under the provision "is simply a suit to enforce the terms of the plan," and not an enforcement mechanism in addition to the exclusive mechanism provided by ERISA. *Id.* at 21a. Applying Section 4-10, the court of appeals reversed the district court's summary judgment in favor of Rush and granted summary judgment to Moran. *Id.* at 24a.

In light of the conflict between the panel's decision and the Fifth Circuit's decision in *Corporate Health*, Seventh Circuit rules required the panel to circulate the opinion to the entire court prior to publication. *See* App. 23a n.7 (citing Circuit Rule 40(e) ("A proposed opinion approved by a panel of this court adopting a position which would * * * create a conflict between or among circuits shall not be published unless it is first circulated among the active members of this court and a majority of them do not vote to rehear en banc the issue of whether the new position should be adopted.")). Four circuit judges voted to rehear the case en banc. Writing for those judges in a dissent from the denial of rehearing en banc, Judge Posner observed that the case "is well worth the attention of the full court." App. 24a. He explained:

> The panel's decision creates a square conflict with another circuit, is probably unsound, and will affect an enormous number of cases. It is also a single-issue case, and the issue is one of law, so that en banc consideration would be unlikely to create a fractured result or bog the

court down in factual questions. Rarely have we had so strong a candidate for en banc review. [*Id.*]

In the view of the dissenters, "[t]he Illinois statute, unless preempted by ERISA insofar as the statute's application to ERISA plans is concerned, will * * * effect a substantial change in the employer's plan." *Id.* at 25a. The state law "establishes a system of appellate review of benefits decisions that is distinct from the provision in ERISA for suits in federal court to enforce entitlements conferred by ERISA plans," and therefore "interferes with the federally specified system for enforcing such entitlements." *Id.* at 25a-26a. The dissenters found the panel's decision "startling," and observed that the panel's reliance on the fiction that state law is incorporated into the plan would permit "transparent * * * evasion[s] of ERISA's preemption clause." *Id.* at 26a-27a.[4]

Finally, the dissenters noted the "unresolved tension in the panel's opinion" between two propositions on which it relied: "first, that the Illinois law regulates insurance rather than ERISA plans and thus is not preempted; second, that by virtue of Illinois law the requirement of independent physician review is written not only into an insurance contract but also into the plan itself, which makes the requirement enforceable in federal court." *Id.* at 27a. Judge Posner explained that "[t]he two propositions are incompatible." *Id.*

> If the statute merely regulates insurance and therefore is not preempted, how can it be part of an ERISA plan and enforceable in federal court? If, on the other hand, the requirement imposed by the statute is and must be incorporated into the plan, then Illinois has done more than merely regulate the contents of an insurance policy. It has regulated the contents of an ERISA plan—which means that its law is preempted. [*Id.*]

[4] The dissenters also concluded that the decision is "in tension with *Pegram* v. *Herdrich*, 120 S. Ct. 2143 (2000)." App. 27a. They stated that "[a]lthough *Pegram* held that combined treatment-eligibility decisions by an HMO are not fiduciary decisions under ERISA, it did not doubt that ERISA applied to HMO-managed ERISA plans; the panel, by contrast, seems to think ERISA inapplicable to such plans." *Id.*

REASONS FOR GRANTING THE WRIT

I. THE SEVENTH CIRCUIT'S DECISION IN THIS CASE DIRECTLY CONFLICTS WITH THE FIFTH CIRCUIT'S DECISION IN *CORPORATE HEALTH*.

As Judge Posner observed in his dissenting opinion, the panel's decision in this case "creates a square conflict" (App. 24a) with the Fifth Circuit's decision in *Corporate Health Insurance, Inc.* v. *Texas Department of Insurance*, 215 F.3d 526 (5th Cir.), *further opinion on pet. for reh'g*, 220 F.3d 641 (5th Cir. 2000), *pet. for cert. filed sub nom., Montemayor* v. *Texas Dep't of Ins.*, 69 U.S.L.W. 3317 (Oct. 24, 2000) (No. 00-665). That fact is reason enough to grant the writ here. *See* S. Ct. R. 10(a); *Braxton* v. *United States*, 500 U.S. 344, 347 (1991) (a "principal purpose for which we use our certiorari jurisdiction * * * is to resolve conflicts among the United States courts of appeals").

In *Corporate Health*, the Fifth Circuit considered a Texas independent review statute that the Seventh Circuit recognized was "quite similar" (App. 19a) to Section 4-10 of the Illinois HMO Act. *See* App. 25a (Posner, J.) (the Texas and Illinois statutes are "materially identical").[5] Like Section 4-10, the Texas statute provides for "the independent review of

[5] *Cf. District of Columbia* v. *Greater Washington Bd. of Trade*, 506 U.S. 125, 129 (1992) (certiorari granted where District of Columbia statute was held preempted by ERISA but a "substantially similar" Connecticut statute had been held not preempted); *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645, 654 (1995) (certiorari granted where New York statute was preempted by ERISA but "similar" New Jersey statute was not).

health care determinations to decide whether they were appropriate and medically necessary" by "allow[ing] a patient who has been denied coverage to appeal to an outside organization." *Corporate Health*, 215 F.3d at 531,. 537. Thus, both laws "require[] HMOs to provide a mechanism for patients to obtain independent review of the need for a course of treatment." App. 19a. Unlike the Seventh Circuit, however, the Fifth Circuit was firmly of the view that "[s]uch an attempt to impose a state administrative regime governing coverage determinations is squarely within the ambit of ERISA's preemptive reach." *Corporate Health*, 215 F.3d at 537.

The Fifth Circuit first found that the independent review statute regulated insurance under ERISA's savings clause based on the application of the "common sense test" and the three McCarran-Ferguson factors. *See id.* at 537-538. The Fifth Circuit recognized that "[o]ur analysis does not end here, however, because even if the provisions would otherwise be saved, they may nonetheless be preempted if they conflict with a substantive provision of ERISA." *Id.* at 538. The Fifth Circuit observed that in *Pilot Life Insurance Co.* v. *Dedeaux*, 481 U.S. 41 (1987), this Court had held that "the exclusivity of ERISA's enforcement scheme * * * preempts not only directly conflicting remedial schemes, but also supplemental state law remedies. Thus, the saving clause does not operate if the state law at issue creates an alternative remedy for obtaining benefits under an ERISA plan." *Corporate Health*, 215 F.3d at 538-539 (footnote omitted).[6]

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[6] This Court held in *Pilot Life*, 481 U.S. at 54, as follows:

> In sum, the detailed provisions of § 502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA.

Applying the *Pilot Life* analysis, the Fifth Circuit held that the independent review provisions of the Texas statute were preempted by Section 502(a) of ERISA, 29 U.S.C. § 1132(a). As Judge Higginbotham explained for the court:

> Here, the independent review provisions * * * establish a quasi-administrative procedure for the review of [benefits] denial and bind the ERISA plan to the decision of the independent review organization. This scheme creates an alternative mechanism through which plan members may seek benefits due them under the terms of the plan—the identical relief offered under § 1132(a)(1)(B) of ERISA. As such, the independent review provisions conflict with ERISA's exclusive remedy and cannot be saved by the saving clause. [*Id.* at 539.]

The State of Texas then sought panel rehearing, relying on the very same argument accepted by the Seventh Circuit in this case. Specifically, Texas "insist[ed] that the [independent review] provisions do not create an alternative mechanism for seeking benefits" but "merely implement[] a procedural right to obtain medical care by imposing a mandatory insurance contract term that goes to the heart of the insured-insurer relationship." 220 F.3d at 644 (quotation marks and ellipses omitted). The panel, however, roundly rejected this "ambitious spin" and denied the petition. *Id.* The Fifth Circuit reaffirmed that "the law is clear that Texas cannot provide a supplementary claims process by binding the HMO to pay for a treatment that is simply a second opinion on medical necessity about which reasonable doctors might reach differing conclusions." *Id.* at 645. The independent review provisions, said the court, "are plainly a state regime for reviewing benefit decisions and not a system for implementing a mandated term of insurance." *Id.*

Texas' petition for rehearing en banc was also denied, with the Fifth Circuit noting that "no member of this panel nor judge in regular active service on the court ha[d] requested that the court be polled on Rehearing En Banc." *Id.*

In sum, there is a direct conflict between the decisions of the Fifth and Seventh Circuits, a fact recognized not only by Judge Posner, but also by the panel itself. *See* App. 19a-21a, 22a n.7. Indeed, because of the Seventh Circuit panel's "respectful disagreement" with the Fifth Circuit (App. 22a n.7), the panel circulated its opinion prior to publication to all active judges on the Seventh Circuit pursuant to a local rule requiring such action whenever a panel proposes an opinion "creat[ing] a conflict between or among circuits." Seventh Cir. R. 40(e). Thus, the inter-circuit conflict has been expressly acknowledged by the court below. *Cf. Travelers*, 514 U.S. at 654 (certiorari granted where Second Circuit had recognized conflict with Third Circuit on ERISA preemption issue).

II. THIS COURT'S RESOLUTION OF THE CONFLICT AMONG THE CIRCUITS IS VITAL, AND THIS CASE IS AN IDEAL VEHICLE FOR RESOLVING THAT CONFLICT.

The matter over which the Fifth and Seventh Circuits are in conflict is an important one. *See* S. Ct. R. 10(a).[7] In recent years, state laws entitling a patient to an independent review or external appeal of an HMO's coverage decisions have

[7] The fact that four Seventh Circuit judges voted to rehear the case en banc also underscores the significance of the issue. *Cf. Boggs* v. *Boggs*, 520 U.S. 833, 838 (1997) (ERISA preemption case in which "[s]ix members of the Court of Appeals dissented from the failure to grant rehearing en banc."). The Secretary of Labor's filing of amicus briefs in the court below and in the Texas case also signals the importance of this case. *See* App. 2a n.1; *Corporate Health*, 215 F.3d at 532 n.5.

proliferated.[8] In 1998, eighteen states had enacted such laws. *See* K. Pollitz, G. Dallek & N. Tapay, Georgetown Univ. Inst. for Health Care Research & Policy, External Review of Health Plan Decisions: An Overview of Key Program Features in the States and Medicare 2-3 & Fig. 1 (Nov. 1998). In 1999, respondent Moran observed that "Illinois is one of at least 25 states now with independent review statutes." Moran 7th Cir. Br. 30. And by 2000, thirty-seven states and the District of Columbia had independent review laws. *See* Pet. for Cert. in *Corporate Health*, No. 00-665, at 29, 27 n.24 (citing statutes).[9] Thus, the question whether ERISA preempts such laws is a recurring one of unquestionable importance. *Cf. Boggs* v. *Boggs*, 520 U.S. at 836 (ERISA preemption issue was "of undoubted importance").[10]

[8] *See, e.g.*, Ariz. Rev. Stat. § 20-2537; Cal. Health & Safety Code § 1374.30; Cal. Ins. Code § 10169; Colo. Rev. Stat. § 10-16-113.5; Conn. Gen. Stat. § 38a-226c-d; D.C. Code § 32-571.7; Fla. Stat. §§ 641.511, 408.7056; Iowa Code §§ 514J.1-514J.14; Kan. Stat. § 40-22a13-a16; La. Rev. Stat. § 22:3081; Md. Ins. Code § 15-10A-05; Mich. Comp. Laws §§ 555.1901-.1929; Minn. Stat. § 62Q.73; Mo. Stat. § 376.1387; Mont. Code § 33-37-102; N.J. Stat. § 26:2S-11; N.Y. Pub. Health L. § 4910; Ohio Rev. Code § 1751.84; Okla. Stat. tit. 63, § 2528.6; Pa. Cons. Stat. tit. 40, § 991.2162; R.I. Gen. Laws § 23-17.12-10; Tenn. Code § 56-32-210; Texas Ins. Code §§ 20A.12A, 21.58A, 21.58C; Vt. Stat. tit. 8, § 4089f; Wash. Rev. Code § 48.43.535.

[9] Some states limit independent or external review to an HMO's determination that a proposed procedure is not medically necessary or appropriate, while others permit such review of a broader range of decisions. *See* G. Dallek & K. Pollitz, Georgetown Univ. Inst. for Health Care Research & Policy, External Review of Health Plan Decisions: An Update 6-7 (May 2000).

[10] Reflecting this Court's appreciation of the importance of resolving ERISA preemption questions is the large number of ERISA preemption cases decided by the Court. *See California Div. of Labor Standards Enforcement* v. *Dillingham Constr., N.A.*, 519 U.S. 316, 334-335 (1997) (Scalia, J., concurring) (noting that

Judge Posner was also exactly on the mark when he stated that Section 4-10 of the Illinois HMO Act "will affect an enormous number of cases" and "effect a substantial change in the employer's plan." App. 24a-25a. In order for an HMO to offer customers health care coverage on an affordable basis, it must limit coverage to those procedures that genuinely are medically necessary and appropriate. For a variety of reasons, individuals may seek many services that are neither. *See Pegram* v. *Herdrich*, 120 S. Ct. at 2149. Section 4-10 of the Illinois HMO Act, like other laws granting a right to external review of medical necessity determinations, "adds heavy new procedural burdens to ERISA plans," and, as Judge Posner observed, "[t]hese burdens do not come without cost." App. 26a. Indeed, "[t]he expense of an arbitration by the independent physician could easily equal the expense of the medical treatment that the HMO had refused to authorize." *Id.* Thus, the perverse, but predictable, effect of laws granting independent review rights is actually to *reduce* available benefits and health care. As Judge Posner noted, "[p]iling on costs in the administration of ERISA plans will shrink benefits and deter some employers from offering health insurance at all." *Id.*

Furthermore, this Court has explained that the basic purpose of ERISA's preemption provision "was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." *Travelers*, 514 U.S. at 657. The Court has also recognized that such a uniform national system "is difficult to achieve * * * if a benefit plan is subjected to differing regulatory require-

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between ERISA's enactment in 1974 and the 1996 Term the Court had granted certiorari in no fewer than 16 cases "to resolve conflicts in the Courts of Appeals regarding ERISA pre-emption of various sorts of state law"); *see also De Buono* v. *NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 808 n.1 (1997) ("The boundaries of ERISA's pre-emptive reach have been the focus of considerable attention from the Court.").

ments in differing States. A plan would be required * * * to process claims in a certain way in some States but not in others." *Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. 1, 9 (1987). "A patchwork scheme of regulation," this Court has said, "would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them." *Id.* at 11.

The Illinois HMO Act and other independent review statutes disrupt the uniformity intended by Congress. Indeed, as Judge Posner explained, every such law "undermines the statutory purpose of federal uniformity in the administration of ERISA plans. If such laws are permissible, the rights of participants in an ERISA plan will change as they are transferred by their employer from state to state, even though they are nominally under the same plan." App. 26a. The various state independent review statutes thus crea an "impediment to an employer's adoption of a uniform benefit administration scheme." *Fort Halifax*, 482 U.S. at 14.

Additionally, the reasoning by which the Seventh Circuit concluded that the independent review scheme established by the Illinois the HMO Act escaped preemption, if taken seriously, would make ERISA's preemption provision meaningless. The panel declared that Section 4-10 was not a mechanism for recovering plan benefits (for if it were it would conflict with ERISA's exclusive remedy) but "ought to be treated as mandated contract terms and treated as part of the insurance contract." App. 23a.

Judge Posner rightly pointed out, however, that such reasoning "invites states to evade the preemptive force of ERISA simply by deeming [their] regulations of ERISA plans to be plan terms." *Id.* at 27a. Such reasoning, for example, "would authorize a state to require ERISA plans to double their benefits"—"transparent[ly] an evasion of ERISA's preemption clause." *Id. See Fort Halifax*, 487 U.S.

at 16 (rejecting state supreme court's view that ERISA does not preempt state-mandated benefit plans because that approach "would permit States to circumvent ERISA's pre-emption provision, by allowing them to require directly what they are forbidden to regulate"); *see also Boggs* v. *Boggs*, 520 U.S. at 844 ("States are not free to change ERISA's structure and balance.").

Finally, this case is an excellent vehicle for resolving the question of ERISA's preemption of state independent review statutes. First, as Judge Posner noted, this is "a single-issue case" (App. 24a)—there is no issue in this case other than the ERISA preemption issue.[11] Second, this case comes to the Court on a well-developed record and in a concrete factual context, after discovery and summary judgment proceedings.[12] Third, representatives of all the interests affected by the Illinois statute are parties to this case—Rush, the HMO; Moran, the ERISA plan participant; and the State of Illinois, whose law is at issue.

III. THERE IS NO REASON FOR THIS COURT TO REFRAIN FROM RESOLVING THE CONFLICT AMONG THE CIRCUITS BECAUSE OF POSSIBLE FUTURE DEVELOPMENTS.

Given the square conflict among the circuits and the importance of the issue presented for review, there is no reason for this Court to let the issue percolate any longer. Indeed, in recent ERISA preemption cases, this Court has rightly declined to let demonstrated inter-circuit conflicts fester.

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[11] Unlike *Corporate Health*, the preemptive effect of the Federal Employee Health Benefits Act ("FEHBA"), 5 U.S.C. § 8901 *et seq.*, is not an issue in this case. *See Corporate Health*, 215 F.3d at 539 (FEHBA preempts Texas independent review law).

[12] In *Corporate Health*, on the other hand, an HMO filed suit to enjoin the Texas statute and have it declared preempted by ERISA immediately after the law took effect. *See Corporate Health*, 215 F.3d at 531.

See, e.g., Dillingham, 519 U.S. at 323 (reviewing 2-1 circuit split); *Travelers*, 514 U.S. at 654 (reviewing 1-1 circuit split); *Greater Washington*, 506 U.S. at 129 (reviewing 1-1 circuit split); *FMC Corp.* v. *Holliday*, 498 U.S. 52, 56 (1990) (reviewing 2-1 circuit split).

The fact that certain bills introduced in the last Congress contained independent review proposals should not cause this Court to depart from its practice of resolving circuit conflicts. It is far from clear that a so-called Patients' Bill of Rights will become law in the foreseeable future or that if such a law were enacted it would include a right to an external appeal of medical necessity determinations applicable to ERISA plans. *See Into the Fire*, Modern Physician, Dec. 1, 2000, at 24 (noting that with an "almost evenly divided" Congress, "government gridlock is going to get worse, not better, making passage of major new healthcare legislation unlikely" and that "a patient bill of rights[] would be tough to implement" even in a political environment conducive to agreement); *Sen. Breaux to Revive Centrist Coalition, Urges Delaying Medicare Reform Debate*, Health Daily News, Dec. 6. 2000 (noting that Senator John Breaux of Louisiana has urged President-elect Bush to delay consideration of health care reform until 2002 and start with "something 'easier' " in his first year in office).

In November 2000, the Department of Labor issued new ERISA regulations to be codified at 29 C.F.R. § 2560.503-1 *et seq*. *See* 65 Fed. Reg. 70,246-65 (discussion of new regulations); *id.* at 70,265-71 (text of new regulations). The new regulations— which apply only to claims filed under a plan on or after January 1, 2002, *see* 29 C.F.R. § 2560.503-1(*o*) (reproduced at 65 Fed. Reg. 70,271)—will require all ERISA plans to provide the opportunity for a "full and fair" *internal* appeal of any adverse benefit determination to "an appropriate named fiduciary of the plan." 29 C.F.R. § 2560.503-1(h) (reproduced at 65 Fed. Reg. 70,268). The

new regulations do not, however, establish any right of *external* appeal.[13]

Furthermore, the new regulations expressly state that they are *not* to be construed as preempting any external appeal available under a state law regulating insurance. *See* 29 C.F.R. § 2560.503-1(k)(2)(i) ("a State law regulating insurance shall not be" preempted "merely because such State law establishes a review procedure to evaluate and resolve disputes involving adverse benefit determinations under group health plans so long as the review procedure is conducted by a person or entity *other than* the insurer, the plan, plan fiduciaries, the employer, or any employee or agent of any of the foregoing") (reproduced at 65 Fed. Reg. 70,270-71) (emphasis added). Thus, the regulations do not preempt state external appeal laws. *See* 65 Fed. Reg. 70,255 ("Subparagraph (k)(2) articulates the Department's view that procedural remedies established by State law that are 'external' to the plan will not be preempted by the regulation."); *id.* at 70,254 (state "external review[]" laws are "beyond the scope of the regulation").

Accordingly, there is no reason for this Court to defer consideration of the questions presented to see what preemptive effect the lower courts give the new regulations vis-à-vis state external appeal statutes.

In issuing its new regulations, the Department of Labor acknowledged the "existing confusion about the possible pre-

[13] With respect to group health plans specifically, the new regulations state that an initial adverse benefit determination must be reviewed by a plan fiduciary who is not the same individual who made the initial determination nor that individual's subordinate, *see* 29 C.F.R. § 2560.503-1(h)(3)(ii), and that in an appeal of an adverse benefit determination based on a judgment that a particular treatment is not medically necessary or appropriate, the reviewing plan fiduciary shall consult with an appropriate health care professional, *see id.* § 2560.503-1(h)(3)(iii). 65 Fed. Reg. 70,269.

emption of State law efforts * * * providing State-mandated systems for the review of disputes between patients and health care providers or insurers." 65 Fed. Reg. 70,254. The Department did not resolve that confusion with its new regulations, nor could it have. This Court can and should.

IV. THE INDEPENDENT REVIEW PROVISION OF THE ILLINOIS HMO ACT IS PREEMPTED BY ERISA.

On the merits of the questions presented, Judge Posner's assessment was again correct: the Seventh Circuit's determination that ERISA does not preempt Section 4-10 of the Illinois HMO Act "is very probably unsound." App. 24a.

Section 514(a) of ERISA, the statute's "express preemption clause," *Boggs* v. *Boggs*, 520 U.S. at 841, broadly states that ERISA shall supersede all State laws to the extent they "relate to" any employee benefit plan. 29 U.S.C. § 1144(a). And it is well established in this Court's cases that ERISA preempts "any state law that refers to or has a connection with covered benefit plans." *Greater Washington*, 506 U.S. at 129-130. "This reading is true to the ordinary meaning of 'relate to,' and thus gives effect to the 'deliberately expansive' language chosen by Congress." *Id.* at 129 (citation omitted) (quoting *Pilot Life*, 481 U.S. at 46).

In the court below, respondents did not dispute that Section 4-10 relates to ERISA plans. *See* App. 15a ("We agree with the parties that § 4-10 of the HMO Act 'relates to' ERISA plans"); App. 25a (Posner, J.) ("The state law is conceded to relate to ERISA plans"). *See also* Amicus Br. of the Secretary of Labor 5 ("Section 4-10 of the Illinois HMO Act does 'relate to' ERISA plans."). Therefore, Section 4-10 may be saved from preemption only if it "regulates insurance" within the meaning of ERISA's savings clause, Section 514(b)(2)(A). 29 U.S.C. § 1144(b)(2)(A).

It does not. As a common sense matter, Section 4-10 "is not a general regulation of insurance, or even of health in-

surance; it is a regulation of HMOs." App. 25a (Posner, J.). Section 4-10 applies to "[e]ach Health Maintenance Organization," 215 Ill. Comp. Stat. 125/4-10, whether the HMO is acting as an insurer or merely the administrator of a benefit plan as to which another entity bears the risk.

Applying the first McCarran-Ferguson factor, Section 4-10 does not have the effect of spreading a policyholder's risk—a point the panel below did not dispute. *See* App. 18a n.3; *see also Corporate Health*, 215 F.3d at 538 (Texas independent review provisions "probably do not meet the first factor of reallocating the risk between the insured and the insurer"). With or without Section 4-10, medical necessity remains the substantive standard (along with other certificate coverages and exclusions) for determining whether the risk of paying for a procedure shall be borne by the HMO or the plan participant.

Section 4-10 also fails to satisfy the final McCarran-Ferguson factor. Section 4-10 is not limited to entities within the insurance industry because HMOs are subject to Section 4-10 even when they perform "administrative services only" roles and do not act as insurers.

Because both the common sense test and two of the three McCarran-Ferguson factors cut against deeming Section 4-10 a regulation of insurance, Section 4-10 is not saved from preemption. In such a case, there is no need to consider whether under the second McCarran-Ferguson factor Section 4-10 is an integral part of the policy relationship between the insurer and the insured. *Cf. Ward*, 526 U.S. at 367-375 (state rule saved since it satisfied the common sense test and the second and third McCarran-Ferguson factors).

But even if Section 4-10 does regulate insurance, the "analysis does not end [t]here," *Corporate Health*, 215 F.3d at 538, because under this Court's *Pilot Life* decision Section 4-10 would still be preempted on the ground that it conflicts with ERISA's exclusive civil enforcement mechanism—as

with ERISA's exclusive civil enforcement mechanism—as the Fifth Circuit and the four dissenting Seventh Circuit judges concluded. *See id.* at 539 (Texas independent review "scheme creates an alternative mechanism through which plan members may seek benefits due them under the terms of the plan" in "conflict with ERISA's exclusive remedy"); App. 25a (Posner, J.) (Section 4-10 "establishes a system of appellate review of benefits decisions that is distinct from the provision in ERISA for suits in federal court to enforce entitlements conferred by ERISA plans.") (citing Section 502(a)(1)(B) of ERISA, 29 U.S.C. § 1132(a)(1)(B)).

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

Respectfully submitted,

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APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

No. 99-2574

DEBRA C. MORAN, PLAINTIFF-APPELLANT,

AND

STATE OF ILLINOIS, INTERVENOR-APPELLANT,

v.

RUSH PRUDENTIAL HMO, INC., DEFENDANT-APPELLEE.

Appeal from the United States District Court
for the Northern District of Illinois, Eastern Division
No. 98 C 442—Suzanne B. Conlon, Judge

Argued April 18, 2000
Decided Oct. 19, 2000

Before: FLAUM, *Chief Judge*, RIPPLE and WILLIAMS, *Circuit Judges*.

RIPPLE, *Circuit Judge*.

Section 4-10 of Illinois' Health Maintenance Organization Act ("the HMO Act"), 215 ILL. COMP. STAT. ANN. 125/1-1 *et seq*., requires HMOs to submit to an independent physician review when there is a disagreement over whether a course of treatment is medically necessary between a patient's primary care physician and the HMO. In the event

that the independent reviewer determines that the treatment is necessary, the HMO is required under § 4-10 of the HMO Act to cover the treatment.

Debra Moran's primary care physician recommended a specific surgery for her, but Rush Prudential HMO, Inc. ("Rush"), the service provider for Ms. Moran's ERISA-governed medical benefits plan, denied coverage for that surgery. Rush offered instead to cover a less expensive surgery to be performed by a Rush-affiliated doctor. At her own expense, Ms. Moran underwent the surgery proposed by her physician. She later sought to enforce her rights under § 4-10 of the HMO Act by bringing an action in state court. Rush removed the action to federal district court on ERISA preemption grounds. After additional proceedings, including a remand to state court and another removal by Rush, the district court granted summary judgment to Rush. The district court determined that § 4-10 of the HMO Act, and Ms. Moran's claims based on that act, were preempted by the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001 *et seq*. The district court also concluded, upon reviewing Rush's decision to deny coverage, that Rush's denial of coverage was not improper. Ms. Moran now appeals.[1] For the reasons set forth in the following opinion, we reverse the judgment of the district court.

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[1] The State of Illinois has intervened to defend the HMO Act. We also have the benefit of three *amicus curiae* briefs: one from the United States Department of Labor; one from the American Medical Association, the Illinois State Medical Society, and the American College of Legal Medicine; and one from the Illinois State Chamber of Commerce and the Employment Law Council of Illinois.

I

BACKGROUND

A.

Ms. Moran is covered by a medical benefits plan sponsored by her husband's employer. The plan is governed by ERISA, and it is fully insured. Rush is the HMO provider for the plan. Two aspects of the plan are worth noting. First, the plan's member certificate delegates to Rush "the broadest possible discretion" to interpret the terms of the plan and to determine which benefits the participants are entitled to receive. R.1-1, Ex. A. at 7. Second, the certificate provides that services that are not "medically necessary" will not be covered by the plan. *Id.* at 21.[2]

B.

Starting in 1996, Ms. Moran began experiencing pain, numbness, loss of function, and decreased mobility in her right shoulder. Ms. Moran sought treatment for these symptoms from Dr. Arthur LaMarre, her primary care physician and a Rush-affiliated physician. At first Dr. LaMarre treated

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[2] The plan documents provide that a service is "medically necessary" if Rush determines that it meets all of the following criteria:

(a) It is furnished or authorized by a Participating Doctor for the diagnosis or the treatment of a Sickness or Injury or for the maintenance of a person's good health.

(b) The prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use, and that its omission would adversely affect the person's medical condition.

(c) It is furnished by a provider with appropriate training, experience, staff and facilities to furnish that particular service . . . .

R.1-1, Ex. A at 21.

Ms. Moran through physiotherapy and other conservative therapies, but these efforts did not relieve her symptoms. While she was undergoing these conservative therapies, Ms. Moran obtained the name of Dr. Julia Terzis, an out-of-network surgeon in Virginia who specializes in microreconstructive surgery. After Rush denied Ms. Moran's request for a out-of-network referral to consult with Dr. Terzis, Ms. Moran traveled on her own accord to Virginia to be examined by Dr. Terzis. Dr. Terzis diagnosed Ms. Moran with brachial plexopathy and thoracic outlet syndrome ("TOS"), a nerve compression syndrome caused by the compression of nerves in Ms. Moran's brachial plexus.

Most nerve compression syndromes are mild and effectively treated with conservative physiotherapy, and surgery is not indicated unless more conservative measures fail to manage the symptoms. If surgery becomes necessary, the standard procedure for TOS involves decompression by way of first rib resection (the complete removal of the uppermost rib) or first rib resection with scalenectomy (the removal of the rib and the attached muscle). If necessary, a surgeon may use loupe magnification, in which the surgeon wears a goggle-like apparatus to magnify the immediate view, to conduct a neurolysis, which is removal of scar tissue surrounding the injured nerve. Dr. Terzis, however, performs a more complicated surgery for patients with Ms. Moran's condition. Dr. Terzis' surgery consists of rib resection, extensive scalenectomy, and, if indicated, microneurolysis of the lower roots of the brachial plexus under intraoperative microscopic magnification. Dr. Terzis concluded that Ms. Moran was a candidate for the more complicated microneurolysis surgery. She also indicated to Ms. Moran that she had successfully treated other patients with Ms. Moran's condition.

After meeting with Dr. Terzis, Ms. Moran asked Dr. LaMarre to obtain approval from Rush for Dr. Terzis' proposed surgery. Dr. LaMarre first had Ms. Moran see two Rush-affiliated thoracic surgeons, Dr. Raymond A. Dieter and Dr. William H. Warren. After examining Ms. Moran, both doctors confirmed Dr. Terzis' diagnosis of TOS and recommended that Ms. Moran undergo the standard TOS surgery. Ms. Moran, however, was not impressed by the prognosis offered by these doctors, and she decided that she wanted to have Dr. Terzis perform her proposed surgery.

On October 14, 1997, Dr. LaMarre asked Rush to approve Dr. Terzis' microneurolysis surgery for Ms. Moran. In his recommendation letter, Dr. LaMarre stated that, in his opinion, Ms. Moran would be "best served" by having Dr. Terzis' procedure performed. R.45, Ex. 5. Rush denied approval on the grounds that Dr. Terzis' surgery was out of network. Ms. Moran appealed the administrator's decision. In response to her appeal, Rush requested additional information from Dr. Dieter and Dr. Warren about Dr. Terzis' proposed surgery and the need for microneurolysis. Both doctors reported that microneurolysis was unnecessary for Ms. Moran. After reviewing the reports of Dr. Dieter and Dr. Warren, and after conducting its own analysis of relevant medical literature, Rush affirmed its denial of coverage for Dr. Terzis' microneurolysis surgery on the ground that the procedure was not "medically necessary" as defined by the plan. In a letter to Ms. Moran, Rush provided a detailed discussion of its reasons for denying coverage for Dr. Terzis' proposed surgery and informed Ms. Moran that it would cover the standard TOS surgery, by a network surgeon, of first rib resection with scalenectomy. Ms. Moran then made a final appeal to Rush's Membership Advisory Committee, but the committee voted to uphold Rush's denial.

The next month, in February 1998, Ms. Moran underwent Dr. Terzis' microneurolysis surgery. The surgery took nearly 14 hours and, with post-operative care, cost $94,841.27. Ms. Moran paid for the surgery herself. Ms. Moran submitted a copy of the bill for her surgery to Rush, and she and Dr. Terzis also submitted other materials related to the surgery. Rush treated these submissions as a renewed benefits claim, and it opened another investigation into whether Ms. Moran's now-completed surgery should be covered.

As part of its investigation, Rush sought the opinions of additional experts, and it provided these experts with Ms. Moran's medical records as well as information concerning Dr. Terzis' microneurolysis surgery. The first two opinions obtained by Rush were from Dr. Gerald Harris and Dr. John C. Alexander. These doctors were skeptical of the need for microneurolysis in Ms. Moran's case, but they admitted that they lacked expertise in the area. Rush next consulted with Dr. Susan E. MacKinnon, the Chief of Plastic and Reconstructive Surgery at Washington University School of Medicine in St. Louis. Dr. MacKinnon opined that Dr. Terzis' microneurolysis was unnecessary.

C.

In January 1998, the month before she underwent surgery, Ms. Moran made a written demand to Rush for it to comply with § 4-10 of the HMO Act. Under the Act, HMOs are required to provide a mechanism for a review by an independent physician when the patient's primary care physician and HMO disagree about the medical necessity of a treatment proposed by the primary care physician. *See* 215 ILL. COMP. STAT. ANN. 125/4-10. Section 4-10 further provides that the HMO must provide the proposed treatment in the event that the reviewing physician determines that it is medically necessary. *See id.* Rush did not act on Ms.

Moran's request, and Ms. Moran then filed a complaint in Illinois circuit court seeking a court order requiring Rush to appoint an independent physician to review her claim. Rush removed the action to federal district court on the ground that ERISA completely preempts Ms. Moran's claim.

The district court remanded the case to the state court. The court noted that preemption is generally a defense and that, under the well-pleaded complaint rule, an anticipated federal defense could not be the basis for removal. Nonetheless, the district court also noted that a "completely preempted" state law claim could be removed, but the court explained, in the ERISA context, only state law claims that conflicted with ERISA's civil enforcement provisions were completely preempted by ERISA. In this case, the district court concluded, Ms. Moran's request for specific performance was not a claim under ERISA's civil enforcement provisions and therefore was not completely preempted. The district court left open the possibility that a claim for reimbursement under § 4-10 of the HMO Act, in contrast to a request to have the independent review performed, might be a claim for benefits that would be completely preempted by ERISA's civil enforcement provisions.

D.

Upon remand, the state court ordered Rush to submit to the independent physician review mandated by the HMO Act. The state court reserved ruling on whether ERISA preempted the portion of § 4-10 that requires the HMO to cover the procedure in the event that the independent physician determines the procedure is medically necessary. Rush and Ms. Moran agreed to have Dr. A. Lee Dellon, an expert in plastic and reconstructive surgery at Johns Hopkins Medical Center, perform the independent review. After reviewing Ms. Moran's case and the details of the surgery performed by Dr.

Terzis, Dr. Dellon concluded that the surgery was medically necessary, including the microneurolysis. Dr. Dellon, however, reported that he would have used loupe magnification, instead of Dr. Terzis' technique, to perform the neurolysis. The procedure proposed by Dr. Dellon would have been less intrusive and less time consuming than the one performed by Dr. Terzis. After Dr. Dellon had completed his independent review, Rush concluded its renewed investigation into whether Ms. Moran's surgery should be covered. Rush's medical director, after reviewing the reports of Dr. MacKinnon and Dr. Dellon along with the reports of the other doctors, concluded that Dr. Terzis' surgery had not been medically necessary. In January 1999, Rush again denied Ms. Moran's benefits claim.

E.

Following the independent review by Dr. Dellon, Ms. Moran asked the state court to require Rush to reimburse her for the surgery. The state court requested that Ms. Moran amend her complaint to clarify the relief she was seeking. Ms. Moran then filed an amended complaint, the First Amended Complaint, seeking enforcement of § 4-10 of the HMO Act and reimbursement for the surgery in the amount of $94,841.27.

After Ms. Moran filed her First Amended Complaint, Rush removed the suit to federal court once again. This time, Rush argued that Ms. Moran's suit was a claim for benefits that was completely preempted and that her claim, therefore, had to be made under ERISA's civil enforcement provision, § 502(a), 29 U.S.C. § 1132(a). Ms. Moran argued that removal was improper because her claim for reimbursement was a state law claim. The district court, relying on our decision in *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1487 (7th Cir. 1996), held that Ms. Moran's claim for

reimbursement properly was recharacterized as a claim for benefits, which meant that her claim was completely preempted because it fell within § 502(a)(1)(B) of ERISA's civil enforcement provision.

Turning to the merits, the district court then addressed Rush's contention that ERISA preempted § 4-10 of the HMO Act and that, therefore, its provisions did not cabin the discretion of the administrator. The court held that ERISA's "saving clause" did not apply because § 4-10 did not meet one of the *McCarran-Ferguson* factors used to determine whether a law regulates insurance for purposes of that clause. According to the district court, § 4-10 of the HMO Act did not transfer or spread policyholders' risk.

Ms. Moran subsequently moved for reconsideration of the district court's ruling. Ms. Moran argued that the district court should reconsider its previous decision in light of the Supreme Court's opinion in *UNUM Life Insurance Co. v. Ward*, 526 U.S. 358 (1999). In *Ward*, the Supreme Court held that a state law need not satisfy all three *McCarran-Ferguson* factors in order for the law to fall within ERISA's saving clause. *See id.* at 374. The district court denied Ms. Moran's motion for reconsideration on the ground that, even if the saving clause saved § 4-10 from preemption, § 4-10 was preempted nonetheless because it fell within the "deemer clause" exception to the saving clause. Under the deemer clause, the district court held, ERISA preempted § 4-10 of the HMO Act "[b]ecause the Illinois HMO Act has the effect of directly regulating employee benefit plans rather than an insurance company." R.53.

F.

Ms. Moran amended her complaint a second time in April 1999, ostensibly to state a claim for reimbursement under § 4-10 of the HMO Act and to avoid stating a claim for

benefits under ERISA. In the alternative, the Second Amended Complaint also alleged ERISA claims under § 502(a)(1)(B) for breach of contract and for breach of fiduciary duty. The parties then filed cross motions for summary judgment, and the district court granted summary judgment to Rush. The district court explained that, regardless of Ms. Moran's efforts to plead only state law claims, she still was making a claim for benefits under § 502(a)(1)(B) because she was seeking reimbursement for her surgery. Proceeding to its analysis of Ms. Moran's claim for benefits, the district court noted that the certificate governing Ms. Moran's benefits gave Rush the "broadest possible discretion" to interpret the plan's terms and to make benefits determinations. R.79 at 10 (citation omitted). Given the standard of review for plans bestowing this kind of discretion, the district court held that Rush was entitled to summary judgment because it had not abused its discretion or acted arbitrarily in denying Ms. Moran's claim for benefits.

II

DISCUSSION

A.

A district court's preemption ruling is a question of law that we review *de novo*. *See Carpenters Local Union No. 26 v. United States Fidelity & Guar. Co.*, 215 F.3d 136, 139 (1st Cir. 2000); *Burlington N. & Santa Fe Ry. v. Doyle*, 186 F.3d 790, 794 (7th Cir. 1999). We also review *de novo* the propriety of the removal of a state action to federal court. *See Tylka v. Gerber Prods. Co.*, 211 F.3d 445, 447 (7th Cir. 2000). Likewise, we review *de novo* a district court's grant of summary judgment. *See Anstett v. Eagle-Picher Indus., Inc.*, 203 F.3d 501, 503 (7th Cir. 2000). It is appropriate to grant summary judgment only when "the pleadings, depositions, answers to interrogatories, and admissions on file,

together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c); *see Celotex Corp. v. Catrett*, 477 U.S. 317, 322-23 (1986).

B.

A defendant may remove to federal court actions originally brought in a state court only when those actions fall within the federal court's original jurisdiction, *see* 28 U.S.C. § 1441(a), which would include "federal question" jurisdiction over cases "arising under the Constitution, laws, or treaties of the United States," 28 U.S.C. § 1331. Ms. Moran maintained throughout the proceedings in the district court that removal was improper because her claims based on § 4-10 of the HMO Act do not arise "under the Constitution, laws, or treaties of the United States." Ms. Moran also makes this argument on appeal.

As we explained in *Speciale v. Seybold*, 147 F.3d 612 (7th Cir.), *cert. denied*, 525 U.S. 1017 (1998), "[t]he determination of jurisdiction on removal involving an ERISA issue is based upon the well-pleaded complaint rule, the ERISA 'complete preemption' exception to that rule and the defense of 'conflict preemption' under ERISA." *Id.* at 614. Under the well-pleaded complaint rule, we look to the state court complaint and not to the defendant's response to determine whether the plaintiff's claim falls under federal question jurisdiction. *See, e.g., Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1486 (7th Cir. 1996). "It is long settled law that a cause of action arises under federal law only when the plaintiff's well-pleaded complaint raises issues of federal law." *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 63 (1987). A defendant's federal defense to a claim arising under state law, therefore, "does not create federal jurisdic-

tion and therefore does not authorize removal." *Blackburn v. Sundstrand Corp.*, 115 F.3d 493, 495 (7th Cir.), *cert. denied*, 522 U.S. 997 (1997).

There exists, however, an exception to the well-pleaded complaint rule for state law claims that have been "completely preempted" by Congress. *See Speciale*, 147 F.3d at 615. This so-called "complete preemption" doctrine really "is not a preemption doctrine but rather a federal jurisdiction doctrine." *Lister v. Stark*, 890 F.2d 941, 943 n.1 (7th Cir. 1989). Even though a complaint may not mention a federal basis of jurisdiction, the complete preemption doctrine "permits 'recharacterization' of a plaintiff's state law claim as a federal claim so that removal is proper." *Speciale*, 147 F.3d at 615 (quoting *Lister*, 890 F.2d at 943).

In *Metropolitan Life*, the Supreme Court held that the civil enforcement provision of ERISA, § 502(a), completely preempts state law causes of action that fall within the scope of that provision. *See* 481 U.S. at 67; *Speciale*, 147 F.3d at 615. One of ERISA's civil enforcement provisions, § 502(a)(1)(B), allows a plan participant or beneficiary to bring a civil action "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B).

In *Jass*, we identified three factors to be used to determine whether a state law claim should be recharacterized as an ERISA claim under § 502(a): (1) "whether the plaintiff is eligible to bring a claim under that section"; (2) "whether the plaintiff's cause of action falls within the scope of an ERISA provision that the plaintiff can enforce via § 502(a)"; and (3) "whether the plaintiff's state law claim cannot be resolved without an interpretation of the contract governed by federal law." 88 F.3d at 1487 (quotation marks and citations omitted). When all three factors are present, the state law claim is properly recharacterized as an ERISA claim under § 502(a). *See id.* at 1489-90.

We agree with the district court that Ms. Moran's state law claims are properly recharacterized as claims for benefits under § 502(a)(1)(B) of ERISA and, therefore, are completely preempted. Ms. Moran's claims certainly satisfy the first two *Jass* factors. First, she is a plan participant and is, therefore, eligible to bring an action under § 502(a)(1)(B). Second, she is seeking to enforce her right to a benefit under her plan. Ms. Moran seeks payment for the surgery. Finally, Ms. Moran's claims meet the third *Jass* factor because they require an interpretation of the insurance contract governing Ms. Moran's right to the independent review. As we explained in *Plumb v. Fluid Pump Serv., Inc.*, 124 F.3d 849 (7th Cir. 1997), Illinois laws automatically are incorporated into all contracts of insurance in that state. *See id.* at 861. Thus, the provisions of § 4-10 of the HMO Act have been incorporated into Ms. Moran's insurance contract. Therefore, the extent and the enforceability of Ms. Moran's right to an independent review necessarily requires an examination of the contract. Thus, Ms. Moran's claims properly are recharacterized as claims for benefits under ERISA's civil enforcement provision, § 502(a)(1)(B), and removal was proper.

C.

Now that we have determined that removal of Ms. Moran's state court claims based on § 4-10 of the HMO Act was proper, we turn to Rush's preemption defense.

The comprehensive scope of ERISA extends to the regulation of employee welfare benefit plans providing "medical, surgical, or hospital care or benefits" for plan participants "through the purchase of insurance or otherwise." 29 U.S.C.

§ 1002(1); *see New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 650-51 (1995). As the Supreme Court explained in *Travelers*, ERISA "does not go about protecting plan participants and their beneficiaries by requiring employers to provide any given set of minimum benefits." *Travelers*, 514 U.S. at 651. Rather, the statute "controls the administration of benefit plans." *Id.* "It envisions administrative oversight, imposes criminal sanctions, and establishes a comprehensive civil enforcement scheme." *Id.*

As provided by § 514 of the statute, ERISA also preempts some state laws. Specifically, ERISA's preemption clause, § 514(a), "broadly" states that state laws are preempted "to the extent that those laws 'relate to any employee benefit plan.' " *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 363 (1999) (quoting § 514(a), 29 U.S.C. § 1144(a)). Section 514, however, contains a saving clause, § 514(b)(2)(A), which qualifies § 514(a) by excepting state laws from preemption when those laws "regulate[ ] insurance." 29 U.S.C. § 1144(b)(2)(A); *see Ward*, 526 U.S. at 367. Still another clause in § 514 serves as an exception to the saving clause exception: the deemer clause, § 514(b)(2) (B), "makes clear that a state law that 'purports to regulate insurance' cannot deem an employee benefit plan to be an insurance company." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 45 (1987) (quoting § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B)).

We address each clause in turn.

1.

For purposes of § 514(a), a state law "relates to" a covered employment benefit plan if it either has (1) "a connection with" or (2) "reference to" such a plan. *E.g.*, *California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 324 (1997); *Travelers*, 514 U.S. at 656;

Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 96-97 (1983). We agree with the parties that § 4-10 of the HMO Act "relates to" ERISA plans because its provisions have a connection with such plans.

To determine whether § 4-10 of the HMO Act "relates to" ERISA plans, we begin by looking at the state statute. Section 4-10 provides, in relevant part:

> Each Health Maintenance Organization shall provide a mechanism for the timely review by a physician holding the same class of license as the primary care physician, who is unaffiliated with the Health Maintenance Organization, jointly selected by the patient (or the patient's next of kin or legal representative if the patient is unable to act for himself), primary care physician and the Health Maintenance Organization in the event of a dispute between the primary care physician and the Health Maintenance Organization regarding the medical necessity of a covered service proposed by a primary care physician. In the event that the reviewing physician determines the covered service to be medically necessary, the Health Maintenance Organization shall provide the covered service.

215 ILL. COMP. STAT. ANN. 125/4-10. From the text of the HMO Act it is apparent that the law does not make "reference to" an ERISA-governed employee benefit plan; no mention is made of ERISA plans, and the law applies to HMOs regardless of whether a patient's coverage is through an ERISA plan. *Cf. Travelers*, 514 U.S. at 656 (noting that the law in question in that case did not make "reference to" ERISA plans because the law's provisions applied regardless of whether the coverage was "secured by an ERISA plan, private purchase, or otherwise").

State laws that "risk subjecting [ERISA] plan administrators to conflicting state regulations" undoubtedly have a "connection with" ERISA plans within the meaning of § 514(a). *FMC Corp. v. Holliday*, 498 U.S. 52, 59 (1990). Here, § 4-10 of the HMO Act requires HMOs, including those that are service providers for ERISA plans, to provide an independent review mechanism and, should the independent reviewer agree with the primary care physician, to pay claims that otherwise might not be paid under the plan. As the Court explained in *Travelers*, state laws that "mandate[] employee benefit structures or their administration" fall within the ambit of ERISA's preemption clause. *Travelers*, 514 U.S. at 658. Section 4-10 of the HMO Act has an effect on how benefit determinations are made and, thus, squarely falls within ERISA's preemption clause.

2.

As we already have noted, however, a state law that "relates to" ERISA plans may nonetheless avoid preemption if that law "regulates insurance" within the meaning of ERISA's saving clause, § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). *See Ward*, 526 U.S. at 363. To determine whether a state law "regulates insurance" within the meaning of the saving clause, we first ask "whether, from a 'common-sense view of the matter,' the contested prescription regulates insurance." *Id.* at 367 (quoting *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 740 (1985)). Next, we consider "three factors employed to determine whether the regulation fits within the 'business of insurance' as that phrase is used in the McCarran-Ferguson Act." *Id.* (citing 15 U.S.C. § 1011 *et seq.*). Of these three factors, the first is "whether the practice has the effect of transferring or spreading a policyholder's risk." *Id.* (quotation marks and citation omitted). The second factor is "whether the practice is an integral part of the policy relationship between the

insurer and the insured." *Id.* (quotation marks and citation omitted). And the third is "whether the practice is limited to entities within the insurance industry." *Id.* (quotation marks and citation omitted). A state law may fall within the saving clause even if it cannot satisfy all three of the *McCarran-Ferguson* factors. *See id.* at 373-74 (stating that the *McCarran-Ferguson* factors are "guideposts" and rejecting the argument that all three are required).

We conclude that § 4-10 of the HMO Act falls within the saving clause because it "regulates insurance" under a common sense understanding and because it meets at least two of the McCarran-Ferguson factors. As a matter of common sense, § 4-10 of the HMO Act regulates insurance because the law is directed at the HMO industry as insurers. We previously have explained that HMOs "are insurance vehicles under Illinois law," *Anderson v. Humana, Inc.*, 24 F.3d 889, 892 (7th Cir. 1994), and § 4-10 of the HMO Act is aimed exclusively at members of the insurance industry, even if the law does not affect the entire insurance industry in Illinois.

Section 4-10 of the HMO Act further regulates insurance under a common sense understanding because the Act's provisions go to the core of the relationship between the insurer and the insured. "It is fundamental insurance law that 'existing and valid statutory provisions enter into and form a part of all contracts of insurance to which they are applicable, and, together with settled judicial constructions thereof, become a part of the contract as much as if they were actually incorporated therein.' " *Plumb*, 124 F.3d at 861 (quoting 2 Lee R. Russ & Thomas F. Segalla, Couch on Insurance 3d § 19:1, at 19-2 to 19-4 (1996)). The provisions of § 4-10 of the HMO Act, therefore, are substantive terms of all insurance policies in Illinois by operation of law. When a law mandates a contract term between parties, whether that term

is characterized as creating a "procedural" or "substantive" right, that law is "integral" to the insurer/insured relationship. *Ward*, 526 U.S. at 374-75 & n.5.

Having determined that § 4-10 of the HMO Act regulates insurance under a common sense understanding, we look next to the *McCarran-Ferguson* factors. Section 4-10 clearly satisfies the second and third *McCarran-Ferguson* factors.[3] The second *McCarran-Ferguson* factor is satisfied because § 4-10 creates a mandatory term in the insurance contract and, thus, "changes the bargain between insurer and insured," *id.* at 374. Moreover, § 4-10 satisfies the third *McCarran-Ferguson* factor because, as we already have explained, the section applies only to HMOs acting as insurers. Thus, the law is limited to entities within the insurance industry.

3.

The "deemer clause," § 514(b)(2)(B), is an exception to the saving clause exception. A law saved from preemption by the saving clause may still be preempted if it falls within the deemer clause. *See FMC Corp.*, 498 U.S. at 61. Under this clause, state laws that purport to regulate insurance by "deeming" a plan to be an insurance company are outside of the saving clause and are subject to preemption. *See id.*

The "deemer clause" is inapplicable to this case. In *FMC Corp.*, the Supreme Court explained that the deemer clause exempts "self-funded ERISA plans from state laws that 'regulate insurance' within the meaning of the saving clause." *Id.* The ERISA plan at issue before us, however, is not a self-funded plan; it is an insured plan. The Supreme Court's interpretation of the deemer clause "makes clear that

[3] Because at least two of the *McCarran-Ferguson* factors are secured, we need not decide whether § 4-10 of the HMO Act transfers or spreads risk. *Cf. Ward*, 526 U.S. at 374.

if a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer's insurance contracts." *Id.* at 64. Rush is the insurer to the ERISA plan at issue in our case, and therefore the deemer clause does not apply. *See Ward*, 526 U.S. at 367 n.2 (stating that, because the plan at issue in that case was not self-insured, the deemer clause was "not at issue"); *Plumb*, 124 F.3d at 859 n.6 (explaining that, because the plan at issue was an insured plan, the deemer clause was inapplicable).

4.

A state law that falls within the saving clause nevertheless may be preempted if that law conflicts with a substantive provision of ERISA. *See Pilot Life*, 481 U.S. at 57. Rush argues that § 4-10 of the HMO Act conflicts with § 502(a)(1)(B) of ERISA's civil enforcement scheme. That provision establishes the right of plan participants or beneficiaries to sue "to recover benefits" under the plan, "to enforce . . . rights" under the plan, or "to clarify . . . rights" under the plan. 29 U.S.C. § 1132(a)(1)(B). Rush invites our attention to a decision from the Court of Appeals for the Fifth Circuit, *Corporate Health Insurance, Inc. v. Texas Department of Insurance*, 215 F.3d 526 (5th Cir. 2000), in which the court considered an independent review statute from Texas that is quite similar to § 4-10 of Illinois' HMO Act.

The Texas independent review statute, like §4-10 of the HMO Act, essentially "allow[s] a patient who has been denied coverage to appeal to an outside organization." *Id.* at 537. The law requires HMOs to provide a mechanism for patients to obtain an independent review of the need for a course of treatment. Specifically, the court explained, the Texas statute states that patients may appeal "adverse determinations," which are defined as determinations that a health care service is not "medically necessary" or "appropriate," to

an independent reviewer. *Id.* (quotation marks and citations omitted). Moreover, under the Texas statute, the HMO must "comply" with the independent reviewer's determination of medical necessity. *Id.* (quotation marks and citation omitted).

Our colleagues in the Fifth Circuit took the view that the Texas law conflicted with ERISA's civil enforcement scheme and therefore was preempted. The court concluded that Texas' independent review statute was preempted, even though it regulated insurance within the meaning of the saving clause, because the statute's provisions were contrary to the civil enforcement scheme established in § 502(a). *See id.* at 539. According to the court, the Texas independent review statute "establish[ed] a quasi-administrative procedure for the review of [a decision to deny benefits] and [bound] the ERISA plan to the decision of the independent [reviewer]." *Id.* "This scheme," the court held, "creates an alternative mechanism through which plan members may seek benefits due them under the terms of the plan—the identical relief offered under [§ 502(a)(1)(B)]." *Id.*

In denying the petition for rehearing, the court further explained that, in its view, the Texas' independent review provision "substitutes the medical judgment of a third party physician for the HMO's, or treating physician's, judgment as to medical necessity." *Corporate Health Ins. Co. v. Texas Dep't of Ins.*, 220 F.3d 641, 644 (5th Cir. 2000). In the view of the court, "the law is clear that Texas cannot provide a supplementary claims process by binding the HMO to pay for a treatment that is simply a second opinion on medical necessity about which reasonable doctors might reach differing conclusions." *Id.* at 645. Although the court left open the possibility that an independent review statute might not run afoul of the exclusivity of ERISA's civil enforcement provisions if the independent review mechanism "regulate[d]

the minimal quality level of medical care provided for covered conditions," the court explained that the Texas statute was "plainly a state regime for reviewing benefit decisions and not a system for implementing a mandated term of insurance regulating a minimal standard of care." *Id.*

In our view, § 4-10 of the Illinois HMO Act cannot be characterized as creating an alternative remedy scheme that conflicts with § 502(a). The independent review scheme created by the Illinois statute is not tantamount to the relief offered under § 502(a)(1)(B). As we already have explained, the provisions of § 4-10 of the HMO Act have been incorporated into Ms. Moran's insurance contract.[4] Thus, a suit by her to enforce the HMO Act's provisions is simply a suit to enforce the terms of the plan—precisely the sort of suit that is contemplated by § 502(a)(1)(B) "to enforce rights" and "to recover benefits" under the plan. Notably, the "sole launching ground" for Ms. Moran's claims to enforce § 4-10 of the HMO Act remains § 502(a). *Ward*, 526 U.S. at 377.[5] Rather than providing an alternative remedy for Ms. Moran to recover benefits, § 4-10 of the HMO Act simply establishes an additional internal mechanism for making decisions about

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[4] Indeed, aside from the fact that the Illinois statute automatically became part of the contract by operation of law, the certificate defining Ms. Moran's rights under the plan incorporated the provisions of § 4-10 of the HMO Act. Specifically, the certificate provides that "[i]f the provisions of this Certificate do not conform to the requirements of any state or federal law that applies to the Certificate, the Certificate is automatically changed to conform with the requirements of that law." R.1-1, Ex. A, at 34.

[5] Although Ms. Moran's pleadings in this litigation purported to assert claims under state law, we already have explained that her claims premised on § 4-10 of the HMO Act must be recharacterized as claims made under § 502(a)(1)(B).

medical necessity and identifies who will make that decision in those instances when the HMO and the patient's primary care physician cannot agree on the medical necessity of a course of treatment. Rather than eliminate the review procedures established by the plan, it simply adds to the contract, by operation of law, an additional dispute resolving mechanism when, despite exhausting the internal review system otherwise provided by the plan, there remains a disagreement between the plan's own experts and the attending physician on the issue of medical necessity.

Nor does the addition of this statutorily mandated provision in the contract alter impermissibly the deferential standard of review required by the language of the plan. Certainly, the administrator's failure to abide by the decision of the outside medical consultant on the issue of medical necessity would constitute an abuse of discretion. The statutorily required provision of the plan requires that the decision of the independent review physician be followed, and it would be an abuse of discretion on the part of the administrator not to observe the command of this provision. However, the different outcome is not because of a change in the standard of review but because of a change in the provisions of the contract.[6]

We also believe that it is inaccurate to say that § 4-10 of the HMO Act conflicts with the fiduciary role of the administrator of the plan. At the outset, it is important to note that

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[6] We note that, in this case, the reviewing physician employed the definition of medical necessity found in the provisions of the plan. Although the parties do not bring the issue to us, and we therefore need not decide it, the use of the plan's definition demonstrates even further that § 4-10 of the HMO Act does not totally disrupt the pre-existing terms of the plan but merely affords the participant an additional protection.

the provisions of § 4-10 of the HMO Act apply only to disputes about whether a covered service is medically necessary in a given case. Other issues, most notably the issue of whether a particular treatment is covered, do not fall within the ambit of the section. Moreover, as we have already noted, even with respect to medical necessity decisions, there is nothing in § 4-10 of the HMO Act that in any way abrogates the pre-existing fiduciary obligations of the administrator. Section 4-10 of the HMO Act merely adds an additional obligation that the fiduciary must observe.

In sum, § 4-10 of the HMO Act requires entities in the business of insurance to provide additional safeguards to preserve the integrity of the decision-making process. Following the example of the Supreme Court of the United States, we believe that such requirements ought to be treated as mandated contract terms and treated as part of the insurance contract. *See Ward*, 526 U.S. at 375-76; *see also Plumb*, 124 F.3d at 861. Unlike the situation in *Pilot Life*, we are not asked here to recognize a state common law doctrine of general applicability but a specific statutory provision aimed at the regulation of the insurance industry. As in *Ward*, we simply accept the state-mandated provision as a provision of the plan and then enforce the contract.[7]

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[7] To the degree that our views differ from those of the Fifth Circuit, we find ourselves in respectful disagreement and therefore have circulated this opinion under Circuit Rule 40(e). The opinion has been circulated among all judges of this court in regular active service. A majority of the judges in active service did not wish to rehear the case en banc. Judges Posner, Coffey, Easterbrook and Diane P. Wood voted to grant rehearing en banc.

D.

In this case, there no longer remains a question of material fact that would preclude judgment as a matter of law. As we already have explained, Ms. Moran's claim for reimbursement really is a claim for benefits made under § 502(a)(1)(B) to enforce her rights under the plan. Moreover, § 4-10 of the HMO Act, as incorporated into the plan by operation of law, entitled Ms. Moran to the independent review conducted by Dr. Dellon. Dr. Dellon determined, in agreement with Ms. Moran's primary care physician, that the surgery performed by Dr. Terzis was "medically necessary." Thus, Ms. Moran is entitled to summary judgment in her favor.

Conclusion

For the foregoing reasons, we reverse the judgment of the district court.

REVERSED

POSNER, *Circuit Judge*, with whom *Circuit Judges* COFFEY, EASTERBROOK, and DIANE P. WOOD join, dissenting from denial of hearing en banc.

This case is well worth the attention of the full court. The panel's decision creates a square conflict with another circuit, is very probably unsound, and will affect an enormous number of cases. It is also a single-issue case, and the issue is one of law, so that en banc consideration would be unlikely to create a fractured result or bog the court down in factual questions. Rarely have we had so strong a candidate for en banc review.

The decision holds that ERISA does not preempt an Illinois statute that requires HMOs to submit to review by an independent physician the decision by the HMO not to cover a treatment deemed medically necessary by the patient's

physician. 215 ILCS 125/4-10. An ERISA medical-benefits plan sponsored by the employer of the plaintiff's husband had delegated the provision of the services to which the plan participants were entitled to an HMO. The plan did not require the HMO to submit disagreements with a plan participant's doctor to arbitration by an independent third party. The Illinois statute, unless preempted by ERISA insofar as the statute's application to ERISA plans is concerned, will thus effect a substantial change in the employer's plan. The state law is conceded to relate to ERISA plans and so it is preempted unless the law merely regulates insurance. *See* 29 U.S.C. §§ 1144(a), (b)(2)(A). In *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358 (1999), the principal basis for the panel's decision, the Supreme Court held that a state law that limited insurance companies' right to ignore late claims when the lateness did not harm the insurance company merely regulated insurance and therefore could lawfully be applied to ERISA plans. As the Fifth Circuit pointed out in the decision with which the panel has gone into conflict, *Corporate Health Insurance, Inc. v. Texas Dept. of Insurance*, 215 F.3d 526 (5th Cir. 2000), the "notice prejudice" law held not preempted in *Ward* was a typical regulation of insurance rather than anything either special to ERISA plans or likely to be mischievous in its impact on those plans. All the law provided was that an insurer couldn't disregard late claims unless it had been harmed by the lateness.

The law in this case, like the materially identical law held preempted by the Fifth Circuit, is not a general regulation of insurance, or even of health insurance; it is a regulation of HMOs, which are the service providers under a great many ERISA medical-benefits plans. The law establishes a system of appellate review of benefits decisions that is distinct from the provision in ERISA for suits in federal court to enforce entitlements conferred by ERISA plans. 29 U.S.C.

§ 1132(a)(1)(B). By doing so, the law interferes with the federally specified system for enforcing such entitlements. The suit for breach of contract envisaged by the statute becomes a suit for judicial review of the independent physician's decision. The Illinois law thus adds heavy new procedural burdens to ERISA plans. These burdens do not come without cost. The expense of an arbitration by the independent physician could easily equal the expense of the medical treatment that the HMO had refused to authorize. Piling on costs in the administration of ERISA plans will shrink benefits and deter some employers from offering health insurance at all. In addition, the Illinois law obviously is intended (responding to the recent torrent of criticisms of HMOs) to tilt the administration of those plans in favor of participants by giving them an additional remedy while not giving any additional remedy to the plan. The law undermines the statutory purpose of federal uniformity in the administration of ERISA plans. If such laws are permissible, the rights of participants in an ERISA plan will change as they are transferred by their employer from state to state, even though they are nominally under the same plan.

Although the panel's opinion is long, it does not respond to the concerns just expressed, although they were forcefully argued in the HMO's brief and in an amicus brief supporting the HMO. All that the panel can find to say in defense of its startling decision, except that it thinks it supported by *Ward*, yet without appreciating the force of the Fifth Circuit's distinction of that case, is that the Illinois law makes the physician-review provision a part of the ERISA plan and so does not disturb the exclusivity of ERISA's scheme for the enforcement of the rights that ERISA plans confer on participants and beneficiaries. Under the panel's view, then, if the plan does not submit a disagreement to review by the independent physician, the participant can sue the plan for a

violation of its terms. This is just a façon de parler. It invites states to evade the preemptive force of ERISA simply by deeming its regulations of ERISA plans to be plan terms. It would authorize a state to require ERISA plans to double their benefits. I am sure the panel would not go so far as to permit so transparent an evasion of ERISA's preemption clause, but the opinion contains nothing that would enable the panel to distinguish that case. Far from being compelled by *Ward*, the panel's opinion is in tension with *Pegram v. Herdrich*, 120 S. Ct. 2143 (2000), which it does not cite. Although *Pegram* held that combined treatment-eligibility decisions by an HMO are not fiduciary decisions under ERISA, it did not doubt that ERISA applied to HMO-managed ERISA plans; the panel, by contrast, seems to think ERISA inapplicable to such plans.

There is another unresolved tension in the panel's opinion. The opinion appears to depend on two propositions: first, that the Illinois law regulates insurance rather than ERISA plans and thus is not preempted; second, that by virtue of Illinois law the requirement of independent physician review is written not only into an insurance contract but also into the plan itself, which makes the requirement enforceable in federal court. The two propositions are incompatible. If the statute merely regulates insurance and therefore is not preempted, how can it be part of an ERISA plan and enforceable in federal court? If, on the other hand, the requirement imposed by the statute is and must be incorporated into the plan, then Illinois has done more than merely regulate the contents of an insurance policy. It has regulated the contents of an ERISA plan—which means that its law is preempted.

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

DEBRA C. MORAN, PLAINTIFF,

v.

RUSH PRUDENTIAL HMO, INC., DEFENDANT.

No. 98 C 442

June 9, 1998

MEMORANDUM OPINION AND ORDER

SUZANNE B. CONLON, *Judge*.

Debra C. Moran ("Moran") filed a complaint for specific performance in the Circuit Court of Cook County against Rush Prudential HMO, Inc. ("Rush"). Moran suffers from brachial plexopathy and thoracic outlet syndrome. Rush denied coverage for a surgical procedure recommended by Moran's physician based on a plan exclusion for services "not medically necessary." Moran seeks independent physician review of the medical necessity of the surgical procedure pursuant to section 4-10 of the Illinois Health Maintenance Organization Act, 215 ILCS 125/1-1 *et seq.* ("the HMO Act"). On January 26, 1998, Rush removed the case to federal court on the grounds that Moran's state law claim was completely preempted by the Employment Retirement Income Security Act of 1974 ("ERISA), 29 U.S.C. § 1001 *et*

seq. Moran moves to remand this case to the Circuit Court of Cook County.

DISCUSSION

I. BACKGROUND PRINCIPLES

Federal question jurisdiction exists for claims "arising under" the Constitution, laws, or treaties of the United States. 28 U.S.C. § 1331. A cause of action arises under federal law when the plaintiff's well-pleaded complaint raises issues of federal law. *Gully v. First National Bank*, 299 U.S. 109 (1936). Federal courts do not have original jurisdiction over a state law claim only because a defense to the claim raises a federal issue. This is true even if the plaintiff anticipates the defense and pleads it in his complaint. *Franchise Tax Bd. v. Construction Laborers Vacation Trust*, 463 U.S. 1, 14 (1983). Under the well-pleaded complaint rule, federal preemption of a state claim is generally a defense; while preemption may extinguish the state claim, it does not convert an otherwise state law claim to one "arising under" federal law. *See id.* Thus, federal preemption does not normally authorize removal of a case from state to federal court. *Id.*

II. ERISA AND COMPLETE PREEMPTION

The Supreme Court has recognized a limited exception to the well-pleaded complaint rule in cases of complete preemption. *See Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987); *Lister v. Stark*, 890 F.2d 941, 943 (7th Cir. 1989). This term is really a misnomer "since the complete preemption doctrine is not a preemption doctrine but rather a federal jurisdiction doctrine." *Lister*, 890 F.2d at 944 n.1; *Bartholet v. Reishauer A.G.*, 953 F.2d 1073, 1075 (7th Cir. 1992). The complete preemption doctrine overrides the general rule that "the plaintiff is master of [her] pleadings." *Bartholet*, 953 F.2d at 1075. Even if a complaint purports to raise only state

law claims, the state-law claims may be recharacterized as a federal claim so that removal is proper. *Taylor*, 481 U.S. at 64; *Lister*, 890 F.2d at 943. Recharacterization occurs when the preemptive force of a statute, as judged by Congress' intent, is so strong as to displace entirely all state law causes of action in the particular area. *See Taylor*, 481 U.S. at 63-67. In other words, in certain situations "federal law so fills every nook and cranny that it is not possible to frame a complaint under state law." *Bartholet*, 953 F.2d at 1075.

The parties dispute whether section 4-10 of the HMO Act falls outside the scope of complete preemption through application of ERISA's "savings clause," 29 U.S.C. § 1144(b)(2)(A). But before addressing that question, it is important to address whether Moran's state-law claim may be properly "recharacterized" in the first instance. Courts have been careful to distinguish complete preemption from the defense of preemption in the ERISA context. Section 514(a) provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . ." This type of preemption has been termed conflict preemption. *Ingersoll-Rand v. McClendon*, 498 U.S. 133, 145 (1990). But the mere fact ERISA preempts a state law cause of action does not mean that the state claim arises under federal law. *See Franchise Tax Bd.*, 463 U.S. at 25-27. "[S]tate law claims that are merely subject to conflict preemption under § 514(a) are not recharacterized as claims arising under federal law" because the federal law serves only as a defense to the state law claims. *Rice v. Panchal*, 65 F.3d 637, 640 (7th Cir. 1995).

ERISA does not completely preempt a state law claim unless the claim falls within the scope of ERISA's civil enforcement provision, section 502(a). 29 U.S.C. § 1132; *Taylor*, 481 U.S. at 64-66. In particular, section 502(a)(1)(B) permits a participant or beneficiary of an ERISA plan to

bring a civil action "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). Complete preemption permits removal "when the plaintiff's own claim "depends on ERISA, and the effort to craft a claim" under state law reflects artful pleading." *Blackburn v. Sunderstrand Corp.*, 115 F.3d 493, 495 (7th Cir. 1997). "If a state law claim has been 'displaced' and therefore completely preempted by § 502(a), then a plaintiff's state law claim is properly 'recharacterized' as one arising under federal law." *Rice*, 65 F.3d at 640 (citations omitted).

Although the defense of conflict preemption does not confer subject matter jurisdiction, there is a noted interrelationship between a finding of complete preemption under § 502(a) and conflict preemption under § 514(a) and conflict preemption under § 514(a). *Rice*, 65 F.3d at 646 n.10. "Where a claim is completely preempted under § 502(a) it is necessarily preempted under § 514(a)." *Id.* But the converse does not hold true, for not every state claim related to ERISA under § 514(a) is completely preempted.

The Seventh Circuit recently identified three factors pertinent to the question of complete preemption under § 502(a). These factors are: "(1) whether the 'plaintiff [is] eligible to bring a claim under that section;' (2) whether the plaintiff's 'cause of action falls within the scope of an ERISA provision that the plaintiff can enforce via § 502(a);' and (3) whether the plaintiff's 'state law claim cannot be resolved without an interpretation of a contract governed by federal law.' " *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1487 (7th Cir. 1996). When all three factors are present, a state-law claim is properly recharacterized as an ERISA section 502(a) claim. *Id.* at 1489. There is no apparent dispute as to the first factor of the *Jass* analysis. Thus, the court looks to

the second and third factors to determine whether Moran's claim is properly recharacterized as a federal claim.

Even assuming the second *Jass* factor is satisfied, the court is unconvinced that the third factor is satisfied in this case. Moran seeks specific performance of the requirements of Section 4-10 of the HMO Act. Section 4-10 of the HMO Act provides as follows:

> Medical Necessity—Dispute Resolution—Independent Second Opinion. Each Health Maintenance Organization shall provide a mechanism for the timely review by a physician holding the same class of license as the primary care physician, who is unaffiliated with the Health Maintenance Organization, jointly selected by the patient (or the patient's next of kin or legal representative if the patient is unable to act for himself), primary care physician and the Health Maintenance Organization in the event of a dispute between the primary care physician and the Health Maintenance Organization regarding the medical necessity of a covered service proposed by a primary care physician. In the event that the reviewing physician determines the covered service to be medically necessary, the Health Maintenance Organization shall provide the covered service.

215 ILCS § 125/4-10.

Rush argues that Moran's state-law claim cannot be resolved without interpreting plan language—specifically, the meaning of the plan exclusion for "Services or Supplies Not medically Necessary." Rush reasons that "nothing in section 4-10 [suggests] the plan beneficiary has the right to have the independent reviewer (1) ignore 'medical necessity' plan language and (2) apply a definition of 'medical necessity' different than that contained in the plan itself." Resp. at 7. Putting to one side the question whether section 4-10 of the

HMO Act contemplates (or could permissibly contemplate) a definition of "medical necessity" different than the definition contained in the plan, there is a question of more immediate concern. The critical question is whether Moran's state-law claim actually requires interpretation of the term "medical necessity." Plainly, it does not.

To be sure, if the plan's definition of medical necessity governs the independent reviewer's analysis, the independent reviewer would need to interpret the plan. But Rush's argument overlooks a vital intermediate step: the court's adjudication of Moran's claim. To adjudicate Moran's state-law claim, it is not necessary to interpret the term "medical necessity." Moran's complaint does not ask the court to make a determination about the medical necessity of the surgical procedure recommended by Moran's physician. Rather, Moran merely seeks compliance with the procedural requirements of Illinois' independent review statute. If her claim is successful and she obtains independent review, then the terms of her health plan may well be implicated in the independent review's analysis. But there is no need to interpret the terms of the plan to adjudicate Moran's request for independent review under the Illinois statute. ERISA does not completely preempt a state law claim unless the claim falls within the scope of ERISA section 502(a). Because of Moran's state-law claim can be resolved without interpreting a contract governed by federal law, her claim is not properly recharacterized as an ERISA claim. *Cf. Jass*, 88 F.3d at 1489.

In addressing Moran's state-law claim, a court may ultimately be convinced that independent physician review as contemplated by section 4-10 of the Illinois HMO Act conflicts with ERISA's civil enforcement scheme. But as previously explained, the possibility that ERISA may preempt a state-law cause of action does not mean the state-law

claim arises under federal law. *See Franchise Tax Bd.*, 463 U.S. at 25-27. "[S]tate law claims that are merely subject to conflict preemption under § 514(a) are not recharacterized as claims arising under federal law" because the federal law serves only as a defense to the state law claims. *Rice*, 65 F.3d at 640. The Illinois courts are fully capable of analyzing section 4-10 of the HMO Act and deciding whether it is preempted by ERISA.

CONCLUSION

Moran's motion to remand is granted. This case is remanded to the Circuit Court of Cook County.

APPENDIX C

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

DEBRA C. MORAN, PLAINTIFF,

v.

RUSH PRUDENTIAL HMO, INC.,) DANT.

No. 98 C 442

March 24, 1999

MEMORANDUM OPINION AND ORDER

SUZANNE B. CONLON, *Judge*.

Debra C. Moran ("Moran") filed a complaint for specific performance in the Circuit Court of Cook County against Rush Prudential HMO, Inc. ("Rush"). Moran suffers from brachial plexopathy and thoracic outlet syndrome. Rush denied coverage for a surgical procedure recommended by Moran's physician based on a plan exclusion for services "not medically necessary." Moran sought independent physician review of the medical necessity of the surgical procedure pursuant to section 4-10 of the Illinois Health Maintenance Organization Act, 215 ILCS 125/1-1 *et seq.* ("the HMO Act"). On January 26, 1998, Rush removed the case to federal court on the grounds that Moran's state law claim was completely preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.* This court found Moran's claim not pre-

empted by ERISA because it did not seek to compel benefits and remanded the case to the Circuit Court of Cook County on June 2, 1998.

On November 2, 1998, the Circuit Court of Cook County granted Moran's request for an independent physician review under the HMO Act. The Circuit Court reserved ruling "on whether there is or is not preemption of that portion of the statute which requires coverage in the event the independent review determines the covered service to be medically necessary." Order of November 2, 1998, at ¶ 4. Following the independent review and recommended surgery, Moran asked the Circuit Court to order reimbursement for the medical expenditures. The Circuit Court requested that Moran amend her complaint to clarify the relief sought from Rush. On February 5, 1999, Moran filed an amended complaint seeking reimbursement from Rush in the amount of $94,841.27. Rush removed the action to this court again on February 12, 1999. Moran moves to remand this case to the Circuit Court of Cook County. Moran also moves for costs and expenses pursuant to 28 U.S.C. § 1447(c) for wrongful removal.

DISCUSSION

I. PROCEDURAL CRITERIA FOR REMOVAL

A defendant may file a notice of removal within 30 days of receiving a copy of the initial pleading setting forth the claim for relief upon which the action is based. 28 U.S.C. § 1446(b). The defendant files a "short and plain statement of the grounds for removal," attaching copies of the process, pleadings, and orders served upon him in the proceeding § 1446(a). If the suit initially plead is not removable, the defendant may file a removal notice "within thirty days after receipt by the defendant, through service or otherwise, of a copy of an amended pleading, motion, order or other paper

from which it may first be ascertained that the case is one which is or has become removable." § 1446(b). However, a case may not be removed on the basis of diversity of citizenship jurisdiction more than one year after the commencement of the action. *Id.*

Moran objects to Rush's removal procedure for two reasons. First, she contends Rush's second removal is improper in form because it does not contain all the relevant pleadings in the suit. Second, Moran asserts Rush waived its right to removal by going forward on the merits of her amended complaint in state court.

Regarding the content of Rush's removal notice, Rush has attached all pertinent papers. Together with its removal notice, Rush has submitted nineteen exhibits, including copies of Moran's amended complaint, previous state court orders, the independent physician's review, and subsequent correspondence between Rush and the independent physician. In sum, Rush has attached to its notice all information necessary in determining whether removal was proper.

Although removal procedures are strictly construed, failure to conform to the attachment rule is not a jurisdictional defect. Wright, Miller & Cooper, 14C Federal Practice and Procedure § 3733. Section 1446(a)'s directive requiring the attachments "is obviously intended to provide the district court with the record materials necessary to enable the court and the litigants to delineate the issues to be tried." *Riehl v. National Mutual Inc. Co.*, 374 F.2d 739, 742 (7th Cir. 1967). In light of § 1446(a)'s purpose, minor defects or omissions are "of no consequence." *Id.* (finding remand for failure to attach a copy of the complaint "would be to elevate form over substance"). Because Rush has included in its notice all papers relevant to the suit upon removal, it has satisfied § 1446(a)'s requirements.

Moran contends Rush waived its right to remove by going forward on the merits of her amended complaint in state court. In support of her argument, Moran cites two district court cases from other circuits finding that substantial activity on the merits of a case in state court constitutes a waiver of the right to remove. Moran would be advised to pay closer attention to the controlling law of this circuit, which holds that the waiver doctrine arise in repose to unclear timing requirements in the removal area and has no place in removal law after the 1948-49 revisions to § 1446(b). *Rothner v. City of Chicago*, 879 F.2d 1402, 1415 (7th Cir. 1989).

Rush has met the procedural requirements for removal. Rush filed its notice of removal with this court seven days after Moran filed the amended complaint that provided a basis for removal. Because Rush argues this court's jurisdiction is based on federal question jurisdiction, not diversity of citizenship, removal is permitted more than one year after the commencement of the action. Finally, Rush has provided the court with the papers needed to decide Moran's motion to remand.

II. SUBSTANTIVE CRITERIA FOR REMOVAL

Federal question jurisdiction exists for claims "arising under" the Constitution, laws, or treaties of the United States. 28 U.S.C. § 1331. A cause of action arises under federal law when the plaintiff's well-pleaded complaint raises issues of federal law. *Gully v. First National Bank*, 299 U.S. 109 (1936). Federal courts do not have original jurisdiction over a state law claim only because a defense to the claim raises a federal issue. This is true even if the plaintiff anticipates the defense and pleads it in his complaint. *Franchise Tax Bd. v. Construction Laborers Vacation Trust*, 463 U.S. 1, 14 (1983). Under the well-pleaded complaint rule, federal

preemption of a state claim is generally a defense; while preemption may extinguish the state claim, it does not convert an otherwise state law claim to one "arising under" federal law. *See id.* Thus, federal preemption does not normally authorize removal of a case from state to federal court. *Id.*

The Supreme Court has recognized a limited exception to the well-pleaded complaint rule in cases of complete preemption. *See Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987); *Lister v. Stark*, 890 F.2d 941, 943 (7th Cir. 1989). This term is really a misnomer "since the complete preemption doctrine is not a preemption doctrine but rather a federal jurisdiction doctrine." *Lister*, 890 F.2d at 944 n.1; *Bartholet v. Reishauer A.G.*, 953 F.2d 1073, 1075 (7th Cir. 1992). The complete preemption doctrine overrides the general rule that "the plaintiff is master of [her] pleadings." *Bartholet*, 953 F.2d at 1075. Even if a complaint purports to raise only state law claims, the state-law claims may be recharacterized as a federal claim so that removal is proper. *Taylor*, 481 U.S. at 64; Lister, 890 F.2d at 943. Recharacterization occurs when the preemptive force of a statute, as judged by congressional intent, is so strong as to displace entirely all state law causes of action in the particular area. *See Taylor*, 481 U.S. at 63-67. In other words, in certain situations "federal law so fills every nook and cranny that it is not possible to frame a complaint under state law." *Bartholet*, 953 F.2d at 1075.

Courts have been careful to distinguish complete preemption from the defense of preemption in the ERISA context. Section 514(a) provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." This type of preemption has been termed conflict preemption. *Ingersoll-Rand v. McClendon*, 498 U.S. 133, 145 (1990). But the mere fact that ERISA preempts a state law cause of action does not mean

that the state claim arises under federal law. *See Franchise Tax Bd.*, 463 U.S. at 25-27. "[S]tate law claims that are merely subject to conflict preemption under § 514(a) are not recharacterized as claims arising under federal law" because the federal law serves only as a defense to the state law claims. *Rice v. Panchal*, 65 F.3d 637, 640 (7th Cir. 1995).

ERISA does not completely preempt a state law claim unless the claim falls within the scope of ERISA's civil enforcement provision, § 502(a). 29 U.S.C. § 1132; *Taylor*, 481 U.S. at 64-66. In particular, § 502(a)(1)(B) permits a participant or beneficiary of an ERISA plan to bring a civil action "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). Complete preemption permits removal "when the plaintiff's own claim depends on ERISA, and the effort to craft a claim under state law reflects artful pleading." *Blackburn v. Sundstrand Corp.*, 115 F.3d 493, 495 (7th Cir. 1997). "If a state law claim has been 'displaced' and therefore completely preempted by § 502(a), then a plaintiff's state law claim is properly 'recharacterized' as one arising under federal law." *Rice*, 65 F.3d at 640 (citations omitted).

Although the defense of conflict preemption does not confer subject matter jurisdiction, there is a noted interrelationship between a finding of complete preemption under § 502(a) and conflict preemption under § 514(a). *Rice*, 65 F.3d at 646 n.10. "Where a claim is completely preempted under § 502(a) it is necessarily preempted under § 514(a)." *Id.* But the converse does not hold true, for not every state claim related to ERISA under § 514(a) is completely preempted.

The Seventh Circuit recently identified three factors pertinent to the question of complete preemption under § 502(a). These factors are: "(1) whether the 'plaintiff [is] eligible to bring a claim under that section;' (2) whether the plaintiff's 'cause of action falls within the scope of an ERISA provision that the plaintiff can enforce via § 502(a);' and (3) whether the plaintiff's 'state law claim cannot be resolved without an interpretation of a contract governed by federal law." *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1487 (7th Cir. 1996). When all three factors are present, a state-law claim is properly recharacterized as an ERISA section 502(a) claim. *Id.* at 1489.

Although in its remand order of June 2, 1998, this court found Moran's claim requesting an independent review did not meet the three *Jass* factors and thus was not preempted by ERISA, the court acknowledged the difference between Moran's then claim for specific performance and a potential future claim to compel benefits: "If her claim is successful and she obtains independent review, then the terms of her health plan may well be implicated in the independent reviewer's analysis." Memorandum Opinion and Order of June 2, 1998, at 7. Indeed, Moran has now altered her claim to compel plan benefits in the form of reimbursement for the surgical procedure recommended by the independent reviewer. Her current claim for reimbursement demands an interpretation of the benefits provided for "medical necessities" under her Rush HMO plan. In other words, her claim requires interpretation of a contract governed by federal law, satisfying the third *Jass* criterion. The first and second criteria are also met by Moran's claim to compel benefits. Regardless of how she characterizes it, Moran's current claim is a § 502(a) denial of benefits claim. *Jass*, 88 F.3d at 1489. Moran asserts her right to have Rush cover the costs of medical treatment pursued outside of her HMO plan.

Rush refused to reimburse her for the treatment. Rush's refusal is a determination of benefits within the meaning of ERISA. *Id.* Accordingly, Moran's claim for reimbursement is preempted by ERISA. *Id. See also Corporate Health Ins. Inc. v. Texas Dept. of Ins.*, 12 F. Supp. 2d 597, 625 (S.D. Tex. 1998) (finding Texas statute providing for independent review for adverse benefit determinations was preempted by ERISA).

Even if a claim meets the three *Jass* criteria for preemption, it may nonetheless fall under an ERISA "savings clause" and avoid preemption. 29 U.S.C. § 1144(b)(2)(A). State statutes that regulate the insurance industry are subject to the savings clause. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985). A statute regulating insurance must meet the following three criteria in order to avoid preemption: 1) the statute has the effect of transferring or spreading a policyholder's risk; 2) the statute is an integral part of the policy relationship between the insurer and insured; and 3) the statute is limited to entities within the insurance industry. *Id.* at 742-43. If a statute fails to satisfy any of the three criteria, the ERISA savings clause does not apply. *CIGNA Healthplan of La. v. Louisiana*, 82 F.3d 642, 650 (5th Cir. 1996).

Illinois' HMO Act does not operate to transfer or spread a policyholder's risk. The HMO Act only applies in individual circumstances when a plan administrator has denied benefits coverage for procedures not recognized as "medical necessities." The HMO Act thus affects the administration and adjudication structure of a health plan in particular instances. It does not affect the disbursement of benefits at large to all policyholders, nor does it mandate or deny a certain class of benefits. *See Metropolitan Life*, 471 U.S. at 744. Accordingly, the HMO Act is not subject to ERISA's savings

clause. Because Moran's claim for reimbursement arises under federal law, removal is proper.

CONCLUSION

Moran's motion to remand and for costs pursuant to 28 U.S.C. § 1447(c) is denied.

APPENDIX D

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

DEBRA C. MORAN, PLAINTIFF,

v.

RUSH PRUDENTIAL HMO, INC., DEFENDANT.

No. 98 C 442

May, 6, 1999

ORDER

SUZANNE B. CONLON, *Judge*.

Debra Moran ("Moran") sues Rush Prudential HMO, Inc. ("Rush") to compel health plan benefits pursuant to the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq*. Rush removed the action to this court for the second time on February 12, 1999. On March 22, 1999, the court denied Moran's motion to remand the suit to the Circuit Court of Cook County. Moran moves for reconsideration.

Motions for reconsideration serve a limited purpose. On reconsideration, a party may not introduce new evidence or legal theories that could have been presented earlier. *Caisse Nationale de Credit Agricole v. CBI Industries, Inc.*, 90 F.3d 1264, 1269 (7th Cir. 1996). Nevertheless, a motion to reconsider may be proper to correct manifest errors of law or

to present newly discovered evidence. *In the Matter of Prince*, 85 F.3d 314, 324 (7th Cir. 1996), *cert. denied*, 117 S. Ct. 608 (1996). Ultimately, a district court may grant a motion to reconsider so long as the court does not abuse its discretion. *Id*.

According to Moran, the Supreme Court's recent decision in *Unum Life Ins. Co. v. Ward*, 97-1868, 1999 U.S. Lexis 2839 (April 20, 1999), affects this court's March 22 ruling. In denying Moran's motion for remand, this court concluded that because the Illinois independent review law, 215 ILCS § 125/4-10 ("Illinois HMO Act"), was not a state law regulating insurance, it was preempted by ERISA and not subject to ERISA's "savings clause." This decision relied on *CIGNA Healthplan of Louisiana v. Louisiana*, 82 F.3d 642, 650 (5th Cir. 1996), which interpreted existing Supreme Court law to require satisfaction of all three McCarran-Ferguson factors before ERISA's savings clause would apply. In *Unum*, however, the Supreme Court clarified its position on the McCarran-Ferguson factors, holding that those factors are considerations to be weighed; none is dispositive by itself. 1999 U.S. Lexis 2839, at *27. Moran argues that upon weighing all the factors, the Illinois HMO Act falls within ERISA's savings clause.

The court need not analyze the three McCarran-Ferguson factors because the Illinois HMO Act is exempt from the savings clause. ERISA preemption analysis is divided into three stages. First, the court determines whether the state law in question is preempted by ERISA as related to an employee benefit plan. 29 U.S.C. § 1144(a); *Safeco Life Ins. Co. v. Musser*, 65 F.3d 647, 650 (7th Cir. 1995). If the state law is preempted, the court decides whether the savings clause "returns to the States the power to enforce those state laws that 'regulat[e] insurance.'" *Maciosek v. Blue Cross & Blue Shield of Wisconsin*, 930 F.2d 536, 539 (7th Cir. 1991); 29

U.S.C. § 1144(b)(2)(A). Even if the McCarran-Ferguson factors are satisfied, the state law might fall within the "deemer clause" exception to the savings clause, removing the statute once again from state enforcement as preempted by ERISA. 29 U.S.C. § 1144(b)(2)(B); *Winstead v. Indiana Ins. Co.*, 855 F.2d 430, 434 at n.4 (7th Cir. 1988).

In its March 22 order, this court did not reach the third part of the ERISA analysis because it determined the Illinois HMO Act was not subject to the savings clause for failure to meet all three McCarran-Ferguson factors. The court now declines to analyze the three factors because the deemer clause exempts the Illinois HMO Act from the savings clause. The deemer clause relieves employee benefit plans from state laws regulating insurance by removing the plans from the savings clause's ambit as defined in 29 U.S.C. § 1144(b)(2)(A). *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990). Although the insurance company that insures the benefit plans remains subject to the savings clause and state law regulation, the ERISA plan is bound by state insurance regulations only "insofar as they apply to the plan's insurer." *Id.* The ERISA plan itself is preempted and exempt from the savings clause. *Id.* Because the Illinois HMO Act has the effect of directly regulating employee benefit plans rather than an insurance company, it is exempt from the savings clause under the deemer clause. 29 U.S.C. §§ 1144(b)(2)(A), (B). Thus, ERISA has preempted the Illinois HMO Act, making removal proper.

APPENDIX E

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

DEBRA C. MORAN, PLAINTIFF,

v.

RUSH PRUDENTIAL HMO, INC., DEFENDANT.

No. 98 C 442

June 15, 1999

MEMORANDUM OPINION AND ORDER

SUZANNE B. CONLON, *Judge*.

Debra Moran ("Moran") sues Rush Prudential HMO, Inc. ("Rush") to compel health plan benefits pursuant to the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.* (Counts II and III). Rush also asserts a claim under § 125/4-10 of the Illinois Health Maintenance Organization Act, 215 ILCS 125/1-1 *et seq.* ("HMO Act") (Count I). Rush moves for summary judgment pursuant to Fed. R. Civ. P. 56.

BACKGROUND

All facts are uncontested unless otherwise stated. At all relevant times, Rush was Moran's health care insurer; Moran was covered through her spouse's plan governed by ERISA. Def. 12M ¶ 1. Prior to October 1997, Moran was diagnosed

with thoracic outlet syndrome, a nerve compression syndrome. *Id.* ¶ 5. Although most nerve compression syndromes are mild and effectively treatable with conservative physiotherapy, more severe sensory or motor deficits may ultimately require surgical management. *Id.* ¶ 6.[1] Surgery is not usually indicted unless conservative measures to manage the syndrome through physiotherapy fail. *Id.* ¶ 7. If surgery becomes necessary, the standard procedure involved decompression by way of first rib resection (complete removal of the uppermost rib) or first rib resection with scalenectomy (removal of the rib and the attached muscle). *Id.* If necessary, three to five power loupe magnification, during which the surgeon wears a goggle-like apparatus that magnifies the immediate view, may be used to conduct a neurolysis (removal of scar tissue surrounding the injured nerve). *Id.*

During the course of treatment, Moran obtained the name of Dr. Julia Terzis ("Dr. Terzis"), a Virginia surgeon not associated with Rush, who performs complicated surgery that consists of rib resection, extensive scalenectomy, and microneurolysis of the lower roots of the brachial plexus under intraoperative microscopic magnification. *Id.* On October 14, 1997, Dr. Arthur LaMarre, ("Dr. LaMarre"), Moran's primary care physician, petitioned Rush for approval of Dr. Terzis' microneurolysis surgery. *Id.* ¶ 13. On October 23, 1997, Rush denied approval, a decision that Moran appealed.

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[1] Moran has moved to strike Dr. Rosenberg's affidavit, which serves as the source of this 12M statement. Moran asserts Dr. Rosenberg's affidavits does not meet Fed. R. Civ. P. 56(e) requirements because it is not based on personal knowledge. However, Dr. Rosenberg's affidavit is in fact founded on his personal knowledge as the medical director for Rush's health plans and the person who reviewed Moran's claim for payment submitted to Rush after her surgery. Therefore, his affidavit satisfied Rule 56(e), and Moran's motion to strike his affidavit is denied.

Id. ¶ 14. In response to her appeal, Rush requested the expert opinions of two board certified thoracic surgeons, Dr. Raymond A. Dieter ("Dr. Dieter") and Dr. William H. Warren ("Dr. Warren"), with whom Moran had previously consulted regarding her nerve compression syndrome. *Id.* ¶ 15. Rush affirmed its denial of coverage for Dr. Terzis' microneurolysis surgery, concluding the procedure was not medically necessary. *Id.* ¶¶ 23, 24. At the same time, Rush informed Moran it would cover the standard thoracic outlet syndrome surgery of first rib resection with scalenectomy. *Id.*

Moran chose to undergo Dr. Terzis' microneurolysis surgery; thereafter Rush received a benefits claim for the costs of the surgery. *Id.* ¶ 25. While investigating Moran's benefits claim, Rush obtained the opinions of two additional experts, Dr Gerald Harris ("Dr. Harris") and Dr. John C. Alexander, Jr. ("Dr. Alexander"). *Id.* ¶ 26. Rush provided all physicians consulted with information concerning Dr. Terzis' microneurolysis surgery and Moran's medical records. *Id.* Because Drs. Harris and Alexander admitted to a certain lack of expertise in the area, Rush consulted with Dr. Susan E. MacKinnon ("Dr. MacKinnon"), the Chief of Plastic and Reconstructive Surgery at Washington University School of Medicine in St. Louis, and Dr. A. Lee Dellon ("Dr. Dellon"), an expert in plastic and reconstructive surgery at Johns Hopkins Medical Center. *Id.* ¶ 28. After reviewing the reports of all experts, Dr. Alan B. Rosenberg ("Dr. Rosenberg"), Rush's medical director, concluded Dr. Terzis' surgery had not been medically necessary and denied Moran's benefits claim on January 18, 1999. *Id.* ¶ 37.

DISCUSSION

I. SUMMARY JUDGMENT STANDARD

A movant is entitled to summary judgment under Rule 56 when the moving papers and affidavits show there is no

genuine issue of material fact and the movant is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c); *Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986); *Unterreiner v. Volkswagen of America, Inc.*, 8 F .3d 1206, 1209 (7th Cir. 1993). Once a moving party has met its burden, the non-moving party must go beyond the pleadings and set forth specific facts showing there is a genuine issue for trial. Fed. R. Civ. P. 56(e); *Becker v. Tenenbaum-Hill Assoc., Inc.*, 914 F.2d 107, 110 (7th Cir. 1990). The court considers the record as a whole and draws all reasonable inferences in the light most favorable to the party opposing the motion. *Fisher v. Transco Services-Milwaukee, Inc.*, 979 F.2d 1239, 1242 (7th Cir. 1992). A genuine issue of material fact exists when "the evidence is such that a reasonable jury could return a verdict for the nonmoving party." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986); *Stewart v. McGinnis*, 5 F.3d 1031, 1033 (7th Cir. 1993).

II. NATURE OF MORAN'S CLAIMS

Moran's summary judgment response first addresses this court's lack of jurisdiction over her claims because they are state law claims not preempted by ERISA. After finding Moran's artful pleading in her first amended complaint constituted nothing more than a claim to compel benefits under ERISA § 502(a) and denying Moran's motion to remand the suit to state court, this court permitted her to file a second amended complaint. *See* Memorandum Opinion and Order of March 22, 1999; Order of April 22, 1999. Although the federal rules demand liberality in granting leave to amend complaints, plaintiffs abuse Fed. R. Civ. P. 15(a) when they merely reframe previously deficient claims in a new complaint. *Foman v. Davis*, 371 U.S. 178 (1962); *Rodgers v. Lincoln Towing Service, Inc.*, 771 F.2d 194 (7th Cir. 1985). Moran's second amended complaint is on the edge of abuse. Generous amendment policy ensures that inarticulate or

misguided plaintiffs with meritorious claims are not forced out of court on a technicality; it does not exist to provide plaintiffs a new forum for relitigating previously rejected arguments in thinly veiled disguise.

Although a plaintiff is master of her claim and may theoretically choose whether to plead under state or federal law, she is limited in her choice of law by the remedy she seeks. *Federated Department Stores, Inc. v. Moitie*, 452 U.S. 394, 397, n.2 (1981). If a plaintiff's desired remedy is controlled entirely by federal law, she cannot properly assert a state law cause of action. If a federal right of action has replaced a state right of action, thus preempting state law, a plaintiff necessarily is stating a federal claim whether or not she wishes to do so and regardless of the language in which the claim is couched. *Avco Corp. v. Aero Lodge No. 735*, 390 U.S. 557 (1968).

Under ERISA, a state law claim is completely preempted and recharacterized by federal law when the claim falls within the scope of ERISA's civil enforcement provision, § 502(a). 29 U.S.C. § 1132; *Met. Life Ins. Co. v. Taylor*, 481 U.S. 58, 64-66 (1987). In particular, section 502(a)(1)(B) permits a participant or beneficiary of an ERISA plan to bring a civil action "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). Complete preemption occurs when the plaintiff's own claim depends on ERISA, regardless of any artful pleading efforts to craft a claim under state law. *Blackburn v. Sundstrand Corp.*, 115 F 3d 493, 495 (7th Cir. 1997). "If a state law claim has been 'displaced' and therefore completely preempted by § 502(a), then a plaintiff's state law claim is properly 'recharacterized' as one arising under federal law." *Rice v. Panchal*, 65 F.3d 637, 640 (7th Cir. 1995) (citations omitted).

The procedural history of this case is instructive in determining the precise nature of Moran's current claims. On January 23, 1998, Moran filed a complaint for specific performance against Rush in the Circuit Court of Cook County, seeking to enforce § 4-10 of the HMO Act. Section 4-10 makes two distinct provisions. First, it requires all health maintenance organizations ("HMOs") to provide independent review in the event of a dispute between die HMO and a primary care physician regarding a proposed patient service. 215 ILCS § 125/4-10. Second, § 4-10 requires the HMO to financially cover the service if the independent review concludes the proposed service is medically necessary. *Id.*

Rush removed the suit to this court claiming ERISA preempted § 4-10 in its entirety. This court remanded the case to state court after finding that Moran's claim for specific performance implicated only § 4-10's first provision, which was not preempted by ERISA. *See* Memorandum Opinion and Order of June 2, 1998. In her first complaint, Moran had not asked the court to interpret the term "medical necessity," a task that could implicate the terms of her health plan and thus subject her claim to preemption. *See id.* at 7. Instead, she merely sought compliance with the Illinois statute's procedural requirements of providing an independent physician reviewer. *See id.*

On November 2, 1998, the state court granted Moran's request for an independent physician review under the HMO Act. The court reserved ruling on whether there is or is not preemption of that portion of the statute which requires coverage in the event the independent review determines the covered service to be medically necessary. *See* Def. Resp. Second Mot. Remand, Ex. C. Following the independent review and recommended surgery, Moran asked the state court to order her reimbursement for the medical expenditures. The state court requested that Moran amend her complaint to

clarify the relief sought from Rush. On February 5, 1999, Moran filed an amended complaint seeking reimbursement for the surgery from Rush in the amount of $94,841.27.

Rush again removed the action to this court on February 12, 1999, asserting that Moran's remaining cause of action constituted a claim for denial of benefits under her health policy plan. On March 22, 1999, this court denied Moran's motion to remand, finding her claim for reimbursement preempted by ERISA's civil enforcement policy in § 502(a). Section 502(a)(1)(B) permits a participant or beneficiary of an ERISA plan to bring a civil action "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). Complete preemption under § 502(a) occurs when three factors are present: (1) the plaintiff is eligible to bring a claim under that section; (2) the plaintiff's state law cause of action falls within the scope of an ERISA provision that can be enforced via § 502(a); and (3) the plaintiff's state law claim cannot be resolved without an interpretation of a contract governed by federal law. *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1487 (7th Cir. 1996). Whereas Moran's claim for specific performance of the independent review itself did not require interpretation of a contract governed by federal law, her claim for reimbursement requires an examination of the benefits owed under her health policy plan. Specifically, § 4-10's "medically necessary" standard must be examined according to the health plan's own standard for coverage in order to determine whether reimbursement is owing. Enforcing the second part of the statute without question or reference to Rush's policy under which Moran is insured would interfere with ERISA's statutory enforcement scheme and would allow a patient to circumvent

the health care plan's denial of benefits by compelling an independent review under the state statute.

After her second motion to remand was denied, Moran amended her complaint a second time, again attempting to state a claim for reimbursement under § 4-10. Her continual references to the Illinois HMO Act notwithstanding, Moran's claims still constitute nothing more than an action to compel health plan benefits. In her three count complaint alleging violation of the Illinois HMO Act and breaches of contract and fiduciary duty under ERISA, Moran frames Rush's alleged harm in terms of its failure timely to provide the independent review and pay for the surgery. By focusing on Rush's alleged failure to provide a timely independent review, Moran attempts to construe the remedy sought as one conferred by the first part of § 4-10, which is not preempted. However, the actual damages she alleges are expenses she was forced to pay for her surgery because Rush did not pay for the procedure. She does not allege she would not have had the surgery had she known Rush would refuse to pay for it. Nor does she allege any other damages stemming from the independent review itself. Her damage allegations simply amount to a claim of harm by Rush's refusal to reimburse her for the surgery. Therefore, Moran's allegations remain a claim to compel benefits under § 502(a). Because the remedy sought arises under federal law, this court has subject matter jurisdiction over Moran's suit.

III. RUSH'S BENEFITS CLAIM DETERMINATION

A. Standard of Review

In refusing to reimburse Moran the cost of her surgery, Rush reviewed the independent physician's conclusions in accordance with its internal guidelines for service coverage. Rush's benefits claim determination is subject to a highly deferential standard; the court may reverse Rush's decision

only if Moran shows the determination was made arbitrarily and capriciously. *Hightshue v. AIG Life Ins. Co.*, 135 F.3d 1144 (7th Cir. 1998). When an ERISA regulated benefit plan grants the administrator or fiduciary discretionary authority to determine benefits eligibility or to construe the terms of the plan, the denial of benefits will be overturned only if the administrator's decision constitutes an abuse of discretion. *Id.* at 1147. "[I]f the decision made by the administrator 'was made rationally and in good faith,' [a court] will not second-guess whether the decision is right." *Id.* (citing *Brown v. Retirement Committee of Briggs & Stratton*, 797 F.2d 5:21, 529 (7th Cir. 1986) (citations omitted)).

The court must uphold a claim decision if the claim administrator "makes an informed judgment that articulates an explanation that is satisfactory in light of the relevant facts, *i.e.* one that makes a 'rational connection' between the issue to be decided, the evidence in the case, the text under consideration, and the conclusion reached." *Exbom v. Central States Southeast and Southwest Areas Health and Welfare Fund*, 900 F.2d 1138, 1143 (7th Cir. 1990) (citations omitted)).

In evaluating whether a claim determination was arbitrary or in other words "downright unreasonable," the court must focus on the information and evidence available before the claim administrator at the time of its determination. *Donato v. Met. Life. Ins. Co.*, 19 F.3d 375, 380 (7th Cir. 1994). Even where a claim administrator has equally plausible but conflicting facts as to whether a particular claim is entitled to coverage, it is not arbitrary and capricious for the claim administrator to conclude the claim is not covered. *See, e.g., Smith v. Office of Civilian Health and Medical Program of the Uniformed Services*, 97 F.3d 950, 956-57 (7th Cir. 1996).

B. Medical Necessity of Moran's Microneurolysis Surgery

The evidence shows Rush did not abuse its discretion or act arbitrarily in denying Moran's benefits claim. In reaching its determination, Rush acted in accordance with the protocol set out in Moran's insurance certificate. Specifically, Moran's certificate afforded Rush "the broadest possible discretion to interpret the terms of the Group Contract and the Certificate and to determine which benefits the Employee and his/her eligible dependents are entitled to receive." Def. Ex. 1 at 7. The certificate also stated the method Rush would use to evaluate the medical necessity of services and coverage. The evaluation method includes an examination of prevailing opinions within the appropriate medical specialty and published reports in authoritative medical literature. *Id.* at 21. To this end, Rush solicited expert opinions of leading physicians in the thoracic outlet syndrome area and requested pertinent literature from Dr. Terzis, the physician who performed Moran's surgery.

All the physicians whom Rush consulted would not have performed the precise procedure executed by Dr. Terzis. After reviewing medical literature and Moran's medical records, the experts consulted concurred that the prevailing technique for treating Moran's case would be a first rib resection with scalenectomy. *See* Def. Exs. 3, 9, 14, 15, 19, 20. Only Dr. Dellon stated he would have done the same type of surgery performed by Dr. Terzis. Def. Ex. 20 at 2. However, when Dr. Dellon further described the surgery he would have performed, his procedure differed significantly from Dr. Terzis' surgery. Whereas Dr. Terzis employed an operating microscope in order to perform an extensive exploration of the right supraclavicular plexus and a microneurolysis of the lower roots of Moran's right brachial plexus, Dr. Dellon uses loupe magnification to perform a less

intrusive and lengthy surgery. Dr. Dellon allowed that the length of surgery can vary based "upon the problems encountered, the surgeon's ability and the degree of care taken." *Id.* But the main difference between Dr. Terzis' fourteen hour operation and Dr. Dellon's two or three hour procedure appears to lie in the extent of peripheral nerve exploration. Prior to surgery, Dr. Terzis informed Moran's primary care physician she wished to perform an extensive exploration to identify all brachial plexus roots. Def. Ex. 4. In contrast, Dr. Dellon concentrates on a smaller area where extensive scar formation is likely. Def. Ex. 20. Dr. Rosenberg considered these differences in making his benefits determination. *See* Rosenberg Aff. ¶ 34.

Dr. MacKinnon, a thoracic outlet syndrome expert who coauthored a book with Dr. Dellon and was recommended to Rush by Dr. Terzis herself, opined based on her extensive experience and literature review that a detailed internal neurolysis creates no benefits over the more standard first rib resection and scalenectomy procedure Rush recommended for Moran. Def. Ex. 19. In fact, Dr. MacKinnon noted a greater danger associated with Dr. Terzis' procedure: "Because a detailed internal neurolysis involves operating directly on the nerve and even at times within the nerve, it can be associate with some damage to the nerve which can be associated with pain." *Id.* Moreover, "[i]f such extensive neurolysis lengthens the time of the operative procedure, then this prolonged general anesthetic exposure can be associated with its own separate risks to the patient." *Id.*

Moran argues the expert opinions Rush solicited are inapposite because they address proper thoracic outlet syndrome surgery, whereas Dr. Terzis treated her for both thoracic outlet syndrome and brachial plexopathy. Moran completely misses the mark in this argument. The entire point of the expert opinions rendered is that Moran's condition did not

require extensive brachial plexopathy treatment. *See, e.g., id.* ("Certainly there does not seem to be any reason to neurolyse the upper part of the plexus").

Moran's final argument concerns Rush's procedure for reviewing her benefits claim. She takes exception with the facts that Dr. Rosenberg's "post-hoc 'elective' decision to re-review Moran's request for coverage" occurred almost a year after her surgery and that "[t]he other physicians who reviewed the surgical outcome did so ex parte, without Ms. Moran's approval or knowledge." Pl. Resp. at 12-13. However, it was Moran's own decision to ignore Rush's previous denial of coverage for Dr. Terzis' proposed surgery and pay for the surgery herself that prompted her renewed benefits claim, which in turn necessitated Dr. Rosenberg's review. Moreover, once Moran renewed her benefits claim and placed the performed surgery at issue, she implicitly gave Rush the authority to review the surgery itself and seek opinions on it. Moran could hardly prefer that Rush seek expert opinions on the surgery's medical necessity with no reference to her particular case. Indeed, the determination of whether a procedure is medically necessary is case specific. In accordance with the policy stated in Moran's health insurance certificate, Rush had full authority to consult with other physicians regarding Moran's treatment and medical history.

CONCLUSION

Moran has not submitted evidence establishing Rush's denial of coverage for Dr. Terzis' surgery was arbitrary and capricious. Accordingly, the motion for summary judgment is granted.

Supreme Court, U.S.
FILED
FEB 20 2001
OFFICE OF THE CLERK

No. 00-1021

IN THE

Supreme Court of the United States

RUSH PRUDENTIAL HMO, INC.,

Petitioner,

v.

DEBRA C. MORAN AND STATE OF ILLINOIS,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

BRIEF IN OPPOSITION FOR RESPONDENT DEBRA MORAN

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QUESTION PRESENTED

The Illinois legislature enacted a law in 1987, found in the Illinois HMO Act, as part of the Illinois Insurance Code, which requires independent review of "medical necessity" determinations where there is a dispute between a patient's primary care physician and an HMO operating in Illinois, about the medical necessity of a proposed procedure. The HMO insurer here, Rush Prudential HMO, specifically adopted state law as part of its insurance policy. The Seventh Circuit held that this state insurance law, specifically and solely directed at the insurance industry, was a state law which regulates insurance, exempt from ERISA's preemptive effect, and was a part of defendant's policy as a matter of law. The question Petitioner seeks to present is more accurately posed in the specific factual context of this case as:

> Whether the "independent review" under Illinois insurance law, specifically adopted by an insurer into its HMO insurance policy, which requires an HMO insurer in Illinois to provide independent review where there is a disagreement between a primary care physician and the HMO's medical director over the medical necessity of a proposed service, is a state law that "regulates insurance" and is saved from ERISA preemption by the ERISA savings clause, 29 U.S.C. § 1144(B)(2)(a), thereby allowing application of said state insurance law to protect Illinois insureds.

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INTRODUCTION

Respondent, Debra C. Moran, respectfully submits that the Petition for Writ of Certiorari should be denied. As this Court expresses in its own Supreme Court Rule 10, "petitions for a writ of certiorari will be granted only for compelling reasons." No such reason exists here. While Respondent does not deny the Seventh Circuit's decision is important because it clarifies the rights of Illinois insureds to enforce the Illinois independent review law, the Seventh Circuit's decision is a straight-forward, proper statutory analysis of the legal effect of the ERISA savings clause, 29 U.S.C. § 1144(B)(2)(a), upon a state insurance law. That decision is consistent with the Supreme Court's pronouncements on ERISA preemption, particularly its most recent decision, *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358 (1999). The Seventh Circuit's decision, based on specific facts, is the classic case decried under this Court's same Supreme Court Rule 10 which states, "a petition for a writ of certiorari is rarely granted when the asserted error consists of erroneous factual findings or the misapplication of a properly stated rule of law."

Petitioner makes much of Justice Posner's dissent from the denial of rehearing *en banc* below, but in doing so ignores the unanimous decision on this case and the fact the great majority of the Seventh Circuit opposed rehearing the case at all. While it is true some states now have independent review laws, the Illinois law has been in effect for thirteen years and this is the first precedent in Illinois with respect to the preemptive effect of ERISA relating to that law. Further, despite the fact that a number of states now have such laws, it appears only two Federal circuit courts have addressed the issue of preemption of independent review. While Petitioner claims there are now many states with independent

review laws, it makes no showing of how many states have provisions like the one at issue here. Petitioner provides no analysis, for example, of whether the laws of the other 36 states, like the Illinois law, are limited to the insurance industry, as they are in Illinois. This is a key factor in addressing the preemptive effect of ERISA, which would make any Supreme Court review of the Seventh Circuit decision, as applied to the specific Illinois independent review law, of limited effect.

Further, Petitioner fails to advise the Court of the pending federal legislation (commonly known as the "Patient's Bill of Rights") under consideration by Congress. While there is partisan disagreement about the Republican and Democratic sponsored bills pending, the one area on which there has been bipartisan agreement is that any Federal legislation will include an independent review feature for medical necessity decisions. *See* Bipartisan Patient Protection Act of 2001, S. 283, 107th Cong. § 104 (2001) (requiring group health plans and health insurance issuers to provide beneficiaries with "independent external review for any denial of a claim for benefits" and allowing beneficiaries to commence a civil action to recover reimbursement and fees where a plan fails to provide reimbursement pursuant to an external review decision in favor of beneficiary); Bipartisan Patient Protection Act of 2001, H.R. 526, 107th Cong. § 104 (2001) (same); Quality Care for the Uninsured Act of 1999, H.R. 2990, 106th Cong. § 1103 (1999) (requiring health plans and health insurance issuers to provide for an external appeals process of a denial of claim or benefits as medically unnecessary or when the coverage decision requires medical judgment and allowing courts of competent jurisdiction to require health plans that do not abide by external review decisions to impose civil

penalties, cease and desist orders, and payment of attorney's fees and costs); and Patients' Bill of Rights Plus Act, S. 1344, 106th Cong. § 121 (1999) (requiring group health plans and health insurance issuers to provide beneficiaries with access to independent external review of adverse coverage determinations and allowing civil actions or other remedies to recover the amount of unpaid reimbursement required by such review, along with necessary legal costs and expenses, including attorney's fees). Therefore, there is no substantial likelihood that review of this case will resolve the preemption issue or that this particular issue will arise "again and again" as Petitioner insists. Rather, it is more likely, as President Bush declared during his campaign, that a patient's bill of rights will be passed which includes an independent review provision required on a national basis.

This fact specific case involving the interpretation of one portion of an Illinois insurance statute voluntarily adopted by the insurer was properly decided below, in accordance with established precedent, and does not warrant Supreme Court review. The Petition should be denied.

STATEMENT OF THE CASE

Plaintiff Debra Moran suffered painful and debilitating conditions in her right shoulder. Petitioner's Appendix ("Pet. App.") 3a. She sought treatment within the HMO insurance network of Rush Prudential HMO, Inc. ("Rush" or "Defendant"). This HMO insurance coverage was purchased and provided as an employee benefit through Ms. Moran's husband's employer. It was a fully insured plan. Pet. App. 3a.

Ms. Moran's HMO primary care physician treated her conservatively at first and referred her in-network to a physical therapist and for specialist consults. Pet. App. 3a-4a. She did not improve and her primary care physician recommended to Rush that it approve a proposed surgery out of network. He concluded it would "best serve" his patient. Pet. App. 5a. In addition, the organization responsible for physician services under the fully-insured Rush plan also approved the proposed out of network surgical services. Rush, however, refused to approve the treatment. Pet. App. 5a. Ms. Moran's appeal within the Plan's guidelines was denied. Pet. App. 5a.

Rush is a licensed Illinois HMO which arranges to provide medical services to patients in Illinois. Rush's HMO policy provided:

> If the provisions of this certificate do not conform to the requirements of any state or federal law that applies to this certificate, the certificate is automatically changed to conform with the requirements of that law.

Pet. App. 21a n.4. Rush refused to provide independent review under the Illinois statute, claiming it did not have to because review of its "medical necessity" decision was preempted by ERISA. Pet. App. 5a-7a.

In January, 1998, Ms. Moran filed suit in state court in Illinois seeking appointment of an independent review physician and enforcement of the Illinois Independent Review Law. Pet. App. 7a. As Ms. Moran's pain and disability was increasing, she paid for the services herself and had the surgery performed out of network. Pet. App. 6a.

The state court ordered independent review. Pet. App. 7a. The parties agreed on the independent reviewer and he submitted his independent review report which found the out of network services were medically necessary. Pet. App. 7a-8a.

Despite the independent reviewer's conclusion, Rush refused to reimburse Ms. Moran for the money she spent to obtain the surgery, hospitalization, and follow-up benefits and care she needed to repair her shoulder. Pet. App. 8a. Ms. Moran asked the state court to enforce the independent review law pursuant to her original prayer for relief. Pet. App. 8a.

In February, 1999, Rush removed to Federal Court on the basis of complete preemption. Pet. App. 8a. The District Court then granted Defendant's Motion for Summary Judgment on Plaintiff's ERISA claims and her claims for breach of fiduciary duty. Pet. App. 9a-10a.

Plaintiff Debra Moran appealed and the Seventh Circuit Court unanimously reversed on October 18, 2000, finding that § 4-10 was not preempted by ERISA, but instead was exempt from preemption by virtue of the savings clause, as a state law which regulates insurance, and therefore finding Debra Moran entitled to summary judgment in her favor. Pet. App. 1a-24a.

REASONS FOR DENYING THE WRIT

I.

THE DECISION IS CORRECT.

A. The Illinois Law Regulates the Content of the Insurance Contract.

This action falls squarely under the Court's decision in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), finding a mandated benefit law requiring minimum mental health benefits exempt from ERISA preemption. The only difference is here "medical necessity" (and hence coverage) is determined on a case by case basis in the rare event a primary case physician within an HMO disagrees with its medical director. Nothing in ERISA prohibits this. The statutory wisdom of the law was determined by the Illinois legislature in a classic act of state insurance regulation.

In contrast, this case does not fall, as Petitioner suggests, under the Court's reasoning in *Pilot Life v. Dedeaux*, 481 U.S. 41 (1987), because it does not provide a different state cause of action and remedy than ERISA. Rather, it provides a substantive, mandated insurance term, which (if the insurance is purchased by an ERISA plan) can be enforced under ERISA, just as the Seventh Circuit concluded. Pet. App. 23a. In *Pilot Life*, Plaintiff sought to enforce state common law causes of action for tortious breach of contract, breach of fiduciary duty and improper claims processing, and sought, *inter alia*, attorneys' fees and punitive damages. 481 U.S. at 43-44. Since § 502 (29 U.S.C. § 1132(a)) itself provides for attorneys' fees and makes no provision for

punitive damages, the court found the claims preempted by ERISA. 481 U.S. at 53-54. But § 502 specifically permits an action "to recover benefits due . . . under the terms of his plan, or to enforce his rights under the terms of the Plan. . . ." 29 U.S.C. § 1132(b)(1)(B). That is what Debra Moran sought here: to recover benefits under and to enforce her rights under the terms of her plan which purchased insurance with an adopted, state mandated independent review provision. She did not seek punitive damages or attorney's fees under state common law. She did not seek to invoke any remedy other than those provided under ERISA.

A common sense review of the issue confirms the Seventh Circuit's decision. There is no doubt that an HMO insurer could voluntarily adopt an independent review provision in its insurance contract (as Rush did here). Indeed, nothing in ERISA's substantive scheme or its enforcement provision, § 502, prohibits such a provision. It follows that if a plan can voluntarily purchase insurance with an independent review provision, then a state, via the insurance regulation exception to ERISA preemption, can require it. That is what occurred here. In the *Pilot Life* case, however, the plan could not voluntarily agree to subject itself to state common law causes of action for damages not covered under ERISA — it could not "agree" that ERISA's enforcement § 502 would not apply — and thus this Court held state common law did not apply.

The issue becomes clearer when viewed in the context of the legal presumptions relating to preemption. Here, ERISA provides an express exception to preemption for state insurance regulation. This Court has indicated that "where Federal law is said to bar state action, a field of traditional state regulation, the Court has worked on the assumption

that the historic police powers of the states were not to be superseded by the federal law unless that was the clear and manifest purpose of Congress." When a party is seeking to apply federal law there is the considerable burden of overcoming the "starting presumption that Congress does not intend to supplant state law." *DeBuono v. NYSA-ILA Med. & Clinical Servs.*, 520 U.S. 806, 820 (1997). By saving such insurance regulation from preemption, ERISA "leaves room for complimentary or dual federal and state regulation of the insurance industry." *John Hancock Mutual Life Ins. Co. v. Harris Trust and Savings Bank*, 510 U.S. 86, 98 (1993). The Seventh Circuit below, the Fifth Circuit and even Justice Posner in dissent, all agree an independent review law falls within the state insurance exception. Respondent submits that to imply that the express exception does not apply because of a conflict with another portion of the statute (*i.e.*, enforcement § 502), there must be a direct conflict where, for example, it would be impossible to comply with the state insurance regulation and ERISA. Such an extreme case is not present here.

This Court gave effect to the facially unrestricted scope of the insurance savings clause in *Metropolitan Life* when it "declined to impose any limitation on the savings clause beyond those Congress imposed in the clause itself and in the 'deemer' clause which modifies it," and concluded that "if a state law 'regulates insurance' as mandated - benefit laws do, it is not preempted." 471 U.S. at 746; *cf. Pilot Life*, 481 U.S. at 56-57 (*Metropolitan Life* clearly "rejected any interpretation of the [insurance] savings clause . . . that saved from preemption 'only state regulations unrelated to the substantive provision's of ERISA' "). In addition, the force of the savings provision's express terms is reinforced by the Supreme Court's frequent recognition

— particularly in recent cases — that ERISA preemption provisions must be read against the background of the "assumption that the historic police powers of the states were not to be superseded by the Federal act unless that was the clear and manifest purpose of Congress." *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995). The decision finding no preemption below was correct. There is no need for Supreme Court review.

B. The Independent Review Law Is a Part of Defendant's Insurance Contract.

The Seventh Circuit's decision distinguishes it from the Fifth Circuit decision in *Corporate Health Ins., Inc. v. Texas Dep't of Ins.*, 215 F.3d 526 (5th Cir.), *further opinion on pet. for reh'g*, 220 F.3d 641 (5th Cir. 2000), *pet. for cert. filed sub nom., Montemayor v. Corporate Health Ins., Inc.*, 169 U.S.L.W. 3317 (Oct. 24, 2000) (No. 00-665) and is exactly right as a matter of law. The Court explained that the provisions of § 4-10 of the HMO Act were incorporated into Ms. Moran's insurance contract, noting that the certificate defining Ms. Moran's rights under the Plan voluntarily incorporated the provisions of § 4-10 specifically. Pet. App. 21a n.4. The Court concluded that "thus, a suit by her to enforce the HMO Act's provisions is simply a suit to enforce the terms of the plan; precisely the sort of suit that is contemplated by § 502(A)(1)(b) 'to enforce rights' and to 'recover benefits' under the plan." Pet. App. 21a. Thus, the Seventh Circuit unanimously concluded that the HMO Act

> requires entities in the business of insurance to provide additional safeguards to preserve the integrity of the decision making process.

> Following the example of the Supreme Court of the United States, we believe that such requirements ought to be treated as mandated contract terms and treated as part of the insurance contract. *See Ward*, 526 U.S. at 375-76; *see also Plumb*, 124 F.3d at 861.

Pet. App.3a.

C. The Independent Review Is Enforceable Through ERISA.

Petitioner's argument that even if the Illinois law were saved by the savings clause from ERISA preemption the provision violates the exclusivity of the ERISA civil enforcement scheme, is also contrary to the most recent Supreme Court precedent on the issue in *UNUM Life Ins. Co. v. Ward*. There, this Court specifically stated:

> Unum and its *amici* assert that even if the notice-prejudice rule is saved under 29 U.S.C. §1144(b)(2)(a), it is nonetheless preempted because it conflicts with substantive provisions of ERISA in three ways. The ruling first contends that the notice-prejudice rule, by altering the notice provisions of the insurance contract, conflicts with ERISA's requirement that plan fiduciaries act "in accordance with the documents and instruments governing the plan." §1104(a)(1)(d). According to Unum, §1104(a)(1)(d) preempts any state law contrary to a written plan term.
>
> Unum's "contra-plan term" argument overlooks controlling precedent and makes scant sense. We

> have repeatedly held that state laws mandating insurance contract terms are saved from preemption under §1144(b)(2)(a). *See Metropolitan Life*, 471 U.S. at 758. ("Massachusetts' mandated benefit law is a law which regulates insurance and so is not preempted by ERISA as it applies to insurance contracts purchased for plans subject to ERISA"); *FMC Corp.*, 498 U.S. at 64 ("If a plan is insured, a state may regulate it indirectly through regulation of its insurer and its insurer's insurance contracts"). Under Unum's interpretation of §1104(a)(1)(d), however, states would be powerless to alter the terms of the insurance relationship in ERISA plans; insurers could displace any state regulation simply by asserting a contrary term in plan documents. This interpretation would virtually "write the savings clause out or ERISA." *Metropolitan Life*, 471 U.S. at 741.

UNUM, 526 U.S. at 375-76.

As *UNUM* argued, Rush now argues in seeking review, that its policy language gives it unlimited discretion to determine "medical necessity" and displaces the state regulation via § 4-10, which requires independent review to determine medical necessity. According to this argument, Illinois is powerless to alter the terms of an insurance policy purchased by fully-insured ERISA plans because Rush, as the insurer, displaced state regulation simply by inserting a contrary term in the plan documents. As in *UNUM*, this interpretation writes the savings clause out of ERISA and renders the Illinois legislature's efforts to regulate HMO insurance in Illinois, across the board, ineffective as to

ERISA fully-insured plans. This is contrary not only to the intent of the Illinois Congress but also to Federal Congressional intent with respect to the savings clause.

If Rush's argument is correct, this means that while the state court and Seventh Circuit Court of Appeals below both found the Illinois provision requiring independent review is not preempted, any efforts to enforce the results of that independent review are supposedly "preempted" under ERISA. This would "pull the teeth" of the Illinois Independent Review statute. Under this argument, while independent review can be required, it has no force or effect and can be disregarded by the HMO insurer, at it was in this case. As a matter of statutory construction, Illinois state and federal courts can enforce the provisions of the Illinois Independent Review statute with respect to fully insured HMO plans operating under Illinois law, and require payment where the independent reviewer concludes there is medical necessity, even if the insured plan is provided under an ERISA plan.

The effect of Rush's argument to this Court is that Rush's "medical necessity" insurance decision must be accorded deference and can only be reviewed according to an arbitrary and capricious standard, even in the face of state insurance law to the contrary. Yet, ERISA does not contain any provision requiring review of an insurance decision according to an arbitrary and capricious standard.[1] Rush cites

1. Even if this argument were correct, *Hightshue v. AIG Life Insurance Co.*, 135 F.3d 1144, 1148 (7th Cir. 1998), provides that ERISA insurers, as fiduciaries "are obligated at a minimum to engage in an intensive and scrupulous *independent* investigation of their options to insure that they act in the best interest of the plan (Cont'd)

no ERISA law or regulation which requires that a claims administrator for insurance purchased by a plan must have exclusive authority to apply and interpret the terms of the insurance. By virtue of the savings clause, the states are free to regulate insurance in this area by enacting review provisions. The independent review law does just that. This type of substantive regulation by state insurance laws is exactly what § 514(b) exempts from ERISA preemption.

D. The Independent Review Law Is A State Insurance Law.

In reaching its conclusion, the Seventh Circuit confirmed that the Illinois Independent Review Provision, § 4-10, was incorporated into the HMO's insurance contract as a matter of law. Pet. App. 13a. The Court also made a thorough statutory analysis of ERISA's savings clause, § 514(B)(2)(a), which qualifies § 514(a) by excepting state laws from preemption when those laws "regulate insurance." Pet. App. 14a. The Court followed Congress' express intent to exempt state laws which regulate insurance from ERISA preemption via the ERISA savings clause. This decision is consistent with this Court's pronouncements on the broad exemption supplied by the savings clause. *See Metropolitan Life Ins. Co.*, 471 U.S. at 733 (holding that ERISA preemption is "substantially qualified by this insurance savings clause.")

The Seventh Circuit's unanimous decision followed the Supreme Court's pronounced standards for determining

(Cont'd)
beneficiaries" (emphasis added). Thus even under ERISA itself independent review would be required here with respect to Plaintiff's alternative claim for arbitrary and capricious conduct, so Supreme Court review is unnecessary.

whether a particular state law "regulates insurance." The Court followed this Court's holding in *Metropolitan Life Ins. Co.*, 471 U.S. 740 that to determine whether a state law "regulates insurance" within the meaning of the savings clause, the court first asks "whether, from a 'common sense view of the matter,' that the contested prescription regulates insurance." The Court also followed *Metropolitan Life*'s holding that because a purpose of the insurance savings clause was to preserve the McCarran-Ferguson Act's reservation of business of insurance to the States, the three factors used to determine whether a state law regulates the business of insurance within the meaning of the McCarran-Ferguson Act are also relevant to the ERISA determination. *Metropolitan Life*, 471 U.S. at 744 n.21. Pet. App. 16a-17a.

The Court's specific finding that the independent review provision of the Illinois HMO Act is a state law which regulates insurance is manifestly correct. The Court properly concluded that

> as a matter of common sense, §4-10 of the HMO Act regulates insurance because the law is directed to the HMO industry as insurers. We previously have explained that HMOs "are insurance vehicles under Illinois law," *Andersen v. Humana*, 24 F.3d 889, 892 (7th Cir. 1994), and §4-10 of the HMO Act is aimed exclusively at members of the insurance industry, even if the law does not affect the entire insurance industry in Illinois.

Pet. App. 17a.

The Seventh Circuit also ruled that the HMO Act regulates insurance under a common sense understanding

because the Act goes to the core of the relationship between the insurer and the insured. This is because insurance law provides that valid statutory provisions become part of all contracts of insurance to which they are applicable and become a part of the contract as if actually incorporated therein. Pet. App. 17a. The Court specifically ruled in accordance with *UNUM*, 526 U.S. 374, 375 n.5, that "when a law mandates a contract term between parties, whether that term is characterized as creating a procedural or substantive right, that law is integral to the insurer/insured relationship." Pet. App. 17a-18a. The Seventh Circuit decision is correct. The Petition should be denied.

E. The Department of Labor Supports the Decision Below.

Finally, Petitioner cites recent Department of Labor regulations relating to the provision of independent review. Petitioner notes that the Department of Labor's new regulations "do not preempt state external review laws." Pet. 21-22. What Petitioner does not tell the Court, however, is that the Department of Labor has already taken a position on the specific issue before the Court. As the government entity responsible for interpretation and enforcement of the ERISA laws, the Department of Labor as amicus below asserted that the Illinois Independent Review statute is not preempted, but is saved from preemption by the savings clause, and should be permitted to be enforced via ERISA. In the amicus brief, the Secretary of Labor specifically argued that:

> The District Court erred by holding that §4-10 of the Illinois HMO Act is not saved from preemption under ERISA §514(B)(2)(a) as a law regulating insurance.

Dept. of Labor Amicus Brief, 8.

It was also argued that:

> Like the notice — prejudice rule in *Ward*, §4-10 "effectively creates a mandatory contract term" that requires the HMO to provide independent review of benefit denials; something the HMO would not otherwise have provided.

Amicus Brief, 14. It was also argued that:

> §4-10 merely requires HMOs to establish a particular mechanism for deciding what the HMO must cover where a dispute arises between the HMO and the primary care physician. The statute neither provides Petitioner with an additional remedy where the HMO refuses to provide the covered service nor an alternative forum in which a participant can obtain the service. In order to enforce a claim for those benefits, the participant still must bring an action under §502(a)(1)(b), which therefore remains "the sole launching ground for an ERISA" benefits claim. *Ward*, 119 S.Ct. at 1391. As in *Ward*, §4-10 simply supplies the "relevant rule of decision" for Moran's §502(a) suit. *Ward*, 119 S.Ct. at 1391. That reasoning is dispositive in this case.

Amicus Brief, 18. Thus, contrary to Petitioner's argument, there is no confusion about the Federal government's view of the preemptive effect of ERISA in this circumstance. ERISA does not preempt.

II.

THE ARGUMENTS BY THE DISSENT ARE CONTRARY TO SUPREME COURT PRECEDENT.

The arguments made by Justice Posner in dissent to the denial of *rehearing en banc* below have been previously rejected by this Court or are simply wrong. They do not support the Petition.

Justice Posner repeatedly claims the Illinois law effects a change in the employer's ERISA plan. Pet. App. 25a, 26a, 27a. This is simply not so. Illinois law requires that an HMO *insurer* provide independent review via § 4-10. It does not *require* that any ERISA covered plan which purchases insurance must purchase insurance which provides for independent review. Rather, *if* an ERISA-sponsored, fully insured plan purchases HMO coverage in Illinois, that coverage will have as a contract term, independent review as set forth in § 4-10. Nothing in this scheme offends ERISA and it is not preempted. Rather, just like the minimum health care benefits requirement under Massachusetts law reviewed in *Metropolitan Life*, 471 U.S. 724, or just like the notice — prejudice rule reviewed by this Court most recently in *UNUM*, 526 U.S. 358, Illinois requires insurers to provide independent review in HMO insurance policies in Illinois. ERISA-sponsored plans are free to purchase or not purchase such insurance. They may self-insure. They may provide traditional, fully insured coverage. They may provide PPO coverage. But in the event they choose HMO coverage in Illinois, that coverage and that *insurance contract* will include an independent review provision as required by § 4-10. This is the classic state regulation of insurance specifically exempted from ERISA preemption by Congress.

The plan does not change. The plan provides an insurance product as one of its benefits. If that insurance product is an HMO insurance plan, it will include an independent review provision. The plan still provides insurance. The terms of the insurance are simply regulated by state law. The Seventh Circuit is correct. There is no reason to review this decision.

Justice Posner implies that the Illinois law somehow directly regulates ERISA plans because "it is a regulation of HMOs which are the service providers under a great many ERISA benefit plans." Pet. App. 25a. Yet, this Court in *California Div. of Labor Standards Enforcement v. Dillingham Constr. N.A.*, 519 U.S. 316, 327 n.5 (1997), found a state apprentice wage law was not preempted by ERISA even though virtually all of the apprenticeship programs at issue appeared to be under ERISA plans.

Justice Posner complains the Illinois law adds procedural burdens which undermine federal uniformity in the administration of ERISA plans. This Court rejected that argument in *Metropolitan Life*, 471 U.S. at 747 ("We also are aware that applicants' construction of the statute would eliminate some of the disuniformities currently facing national plans that enter into local markets to purchase insurance. Such disuniformities, however, are the inevitable result of the congressional decision to 'save' local insurance regulation. Arguments as to the wisdom of these policy choices must be directed at Congress."). *See also UNUM*, 526 U.S. at 376 n.6. Any claimed "disuniformity" is a risk that Congress specifically accepted when it exempted state insurance regulation from ERISA preemption. The law does not undermine the statutory purpose of federal uniformity in the administration of ERISA plans because state insurance regulation was specifically exempted from such regulation.

See UNUM:

> We reject *Unum*'s suggestion that because the notice-prejudice rule regulates only the administration of insurance policies, not their substantive terms, it cannot be an integral part of the policy relationship. *See*, *Metropolitan Life*, 471 U.S. at 728, n.2 (including laws regulating claims practices and requiring grace periods in catalogs of state laws that regulate insurance).

UNUM, 526 U.S. at 375 n.5.

Justice Posner finally suggests the Illinois law will increase the costs of insurance to ERISA plans. The Court also rejected that argument for preemption in *Travelers Ins. Co.*, 514 U.S. at 661 ("Indeed, to read the pre-emption provision as displacing all state laws affecting costs and charges on the theory that they indirectly relate to ERISA plans that purchase insurance policies or HMO memberships that would cover such services would effectively read the limiting language in §514(a) out of the statute. . . .") and *DeBuono*, 520 U.S. 816 ("Any state [law] . . . that increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is preempted by the Federal statute.").

III.

THE COURT SHOULD NOT HOLD THIS CASE PENDING DISPOSITION OF THE CORPORATE HEALTH CASE.

Petitioner relies heavily on *Corporate Health Ins.*, 215 F.3d 526, in support of its petition for certiorari on the basis that *Corporate Health* is inconsistent with the holding in Moran below. The *Corporate Health* case however, was decided on a sterile record, based on a challenge to the statute as a whole. It was not based, as here, on an individual insured's action for coverage of a specific procedure under a particular insurance policy. Because of the differences between that case and this one, its outcome will have no dispositive effect on this case.

First, here the insurer voluntarily incorporated the Illinois law into its policy. Pet. App. 21a n.4. In *Corporate Health*, no specific insurance policy was considered, so the decision has no bearing on the effect of ERISA preemption with respect to a voluntary contract term.

Second, the policy here was fully insured and thus is not "deemed" to be the plan itself for preemption purposes. Again, in *Corporate Health*, the Court was not confronted with any particular insurance policy, so it could not address the specific issue of the effect of the savings clause on a fully insured policy, not subject to the "deemer" clause. Supreme Court review of the *Corporate Health* case will not dispose of this action and the Court should not hold this case pending disposition of that matter should it be accepted for review.

IV.

RUSH'S OTHER ARGUMENTS ARE WRONG AND DO NOT SUPPORT REVIEW.

Rush still argues § 4-10 is not the regulation of insurance. Pet. Brief 23-24. It is, as discussed in § I.D above and as noted by the unanimous Seventh Circuit decision below (Pet. App. 14a-19a) and by the Petitioner's own citation to the Fifth Circuit decision in *Corporate Health*. Even the dissent to denial of rehearing *en banc* below does not dispute this conclusion. Pet. App. 24a-27a.

Finally, Rush cites Justice Posner's dissent that this is a single issue case in support of its request for review. It is not a single issue case, however, as Plaintiff raised the alternative claim below, both in the trial court and on appeal, that Rush acted in an arbitrary and capricious manner in denying coverage, an inherently factual and case-specific inquiry. Moran's App. Brief, pp. 31-42. Indeed, Plaintiff's third statement of issue presented for review below was:

> Assuming jurisdiction *arguendo*, is there a question of fact about whether Defendant acted arbitrarily and capriciously in denying the medical necessity of Plaintiff's surgery, contrary to the conclusions of the independent reviewer, treating surgeon and primary care physician.

App. Brief, p. 1. Thus, Supreme Court review will not be entirely dispositive of even this case.

CONCLUSION

For all these reasons, Respondent respectfully submits the Petition should be denied.

Respectfully submitted,

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Supreme Court, U.S.
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No. 00-1021

IN THE

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RUSH PRUDENTIAL HMO, INC.,
Petitioner,

v.

DEBRA C. MORAN AND STATE OF ILLINOIS,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

REPLY BRIEF FOR PETITIONER

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REPLY BRIEF FOR PETITIONER[1]

1. In dissenting from denial of the petition for rehearing en banc in the Seventh Circuit, Judge Posner observed that the panel decision in this case "creates a square conflict" with the Fifth Circuit's decision in *Corporate Health Ins., Inc.* v. *Texas Dep't of Ins.*, 215 F.3d 526 (5th Cir.), *further opinion on pet. for reh'g*, 220 F.3d 641 (5th Cir. 2000), *pet. for cert. filed sub nom., Montemayor* v. *Corporate Health Ins., Inc.*, 69 U.S.L.W. 3317 (Oct. 24, 2000) (No. 00-665). *See* Pet. App. 24a. Indeed, the panel itself recognized that its decision was in conflict with the Fifth Circuit's decision in

[1] Petitioner's Rule 29.6 Statement appears at Pet. ii.

Corporate Health. Pet. App. 23a n.7. Despite the obvious pertinence of *Corporate Health* to the Court's consideration of the petition in this case, Respondent Moran's Brief in Opposition ("Opp.") simply ignores the fact that, on January 8, 2001, this Court invited the Solicitor General to file a brief expressing the views of the United States in *Corporate Health*.[2]

Even respondent recognizes, however, that the views of the government are pertinent to the ERISA preemption question presented here. *See* Opp. 15-16 (contending that the Department of Labor supports the decision below). Thus, in all events, the Court should hold the petition in this case pending receipt of the Solicitor General's response to this Court's invitation in *Corporate Health*.

2. Respondent's effort to forestall that obvious course of action by citing perceived differences between this case and *Corporate Health* is unavailing. She contends that a decision in *Corporate Health* "will not dispose of this action" because *Corporate Health* "was decided on a sterile record," and not, as here, "on an individual insured's action for coverage of a specific procedure under a particular insurance policy." Opp. at 20. If anything, however, those factors make this case a *more* compelling one for plenary consideration than *Corporate Health*. Unlike *Corporate Health*, this case comes to the Court on a well-developed record and in a concrete factual setting, after discovery and summary judgment proceedings. It thus bears more of the hallmarks of "a dis-

[2] The State of Illinois, which is also a respondent, has responded to the obvious circuit conflict by waiving its right to file a Brief in Opposition.

pute capable of judicial resolution," which the Court has identified as "sharply presented issues in a concrete factual setting and self-interested parties vigorously advocating opposing positions." *United Sates Parole Comm'n* v. *Geraghty*, 445 U.S. 388, 403 (1980).

Of course, if the Court is concerned that apparent differences between this case and *Corporate Health* might affect a determination of which of these conflicting cases it ought to review, it could invite the Solicitor General to express the views of the United States in this case as well. No response to the *Corporate Health* invitation has been filed, and the Solicitor General would therefore still have the opportunity to offer the views of the United States on these cases in a comprehensive way.

3. Respondent does suggest that pending federal legislation might forestall the need for review here.[3] The existence of legislative proposals—particularly ones that are the subject of "partisan disagreement," Opp. at 2—hardly provides a basis for this Court to deny review of a live conflict in the courts on a question of widespread importance. Even a passing familiarity with the legislative process counsels against predicting the outcome of any that process. To suggest that the Court simply stand by in the hopes that a Congress attempting to resolve "partisan disagreement" over particular bills might one day reach a resolution on the issue involved here is to disregard this Court's responsibility for resolving existing disagreements between the federal circuits. Respon-

[3] Moran claims that we "fail[ed] to advise the Court" of the existence of such legislation. Opp. at 2. Not so. *See* Pet. at 21.

dent's chimerical hopes for a legislative solution provide no basis for declining to review the decision below.

4. Turning to the question whether the Court should grant review, we agree with several key points in the Opposition. First, respondent Moran "does not deny that the Seventh Circuit's decision is important." Opp. at 1. Second, she recognizes that "a number of states now have [independent review] laws" like the one at issue here. *Id.* Third, although she makes a passing effort to distinguish the Fifth Circuit's decision in *Corporate Health* on the merits, *see* Opp. at 9, 20, she recognizes at least that the decisions are in serious tension with one another. As noted, the Seventh Circuit itself has no doubt that that cases are in conflict. For the reasons explained in the Petition, these factors alone counsel strongly in favor of review, Pet. at 13-20, and Moran offers no effective response to our demonstration that the factors normally motivating this Court to grant certiorari are present here.

Instead, the Brief in Opposition is largely devoted to Moran's attempt to demonstrate that the Seventh Circuit panel decision is correct. *See* Opp. at 6-19. Needless to say, however, where there is an obvious conflict between the circuits, and where the court below was sharply divided (not, as Moran suggests, "unanimous," Opp. at 9, 13), Moran's extended discussion of the *merits* of the issue is misguided and premature. We of course analyze the issue quite differently, Pet. at 23-25—as did the Fifth Circuit and the dissent from denial of rehearing in the Seventh Circuit—but there will be time enough for those arguments if the Court grants review.

For now, the Court should hold the petition here pending receipt of the views of the United States in *Corporate Health*. After the submission of supplemental briefs pursuant to S. Ct. Rule 15.8 commenting on those views, the Court should grant the petition to resolve the acknowledged circuit conflict.

CONCLUSION

For the foregoing reasons, and those stated in the petition, the petition for a writ of certiorari should be granted.

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In the Supreme Court of the United States

JOSÉ MONTEMAYOR, COMMISSIONER, TEXAS DEPARTMENT OF INSURANCE, ET AL., PETITIONERS

v.

CORPORATE HEALTH INSURANCE, INC., ET AL.

RUSH PRUDENTIAL HMO, INC., PETITIONER

v.

DEBRA C. MORAN, ET AL.

ON PETITIONS FOR WRITS OF CERTIORARI TO THE UNITED STATES COURTS OF APPEALS FOR THE FIFTH AND SEVENTH CIRCUITS

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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QUESTIONS PRESENTED

1. Whether state laws providing for external independent review of managed care organizations' medical necessity decisions are preempted by the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001 *et seq.*

2. Whether state laws providing for external independent review of managed care organizations' medical necessity decisions are preempted by the Federal Employees Health Benefits Act of 1959, 5 U.S.C. 8901 *et seq.* (No. 00-665 only.)

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No. 00-665

JOSÉ MONTEMAYOR, COMMISSIONER, TEXAS DEPARTMENT OF INSURANCE, ET AL., PETITIONERS

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No. 00-1021

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ON PETITIONS FOR WRITS OF CERTIORARI TO THE UNITED STATES COURTS OF APPEALS FOR THE FIFTH AND SEVENTH CIRCUITS

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

This brief is submitted in response to the Court's invitations to the Solicitor General to express the views of the United States.

STATEMENT

1. a. *Montemayor.* The *Montemayor* case involves a challenge to a 1997 law (Senate Bill 386), enacted by the State of Texas as an amendment to its insurance code, which, among other things, creates an independent review organization (IRO) process for certain decisions by a health maintenance organization (HMO). 00-665 Pet. App. B2-B3, E1-E7. That process provides for binding external review by an independent physician, at the request of an enrollee, Tex. Ins. Code Ann. § 21.58A (West Supp. 2001), of decisions made "by a

health maintenance organization or a utilization review agent that the health care services furnished or proposed to be furnished to an enrollee are not medically necessary or are not appropriate." *Id.* § 20A.12A(a)(1).

b. Shortly after the passage of the law, Corporate Health Insurance, Inc., and a number of other HMOs and insurers brought suit in the United States District Court for the Southern District of Texas against the Texas insurance commissioner and the state attorney general, arguing that the Texas law is preempted by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.*, and the Federal Employees Health Benefits Act of 1959 (FEHBA), 5 U.S.C. 8901 *et seq.* The district court held that the provisions of the Act that impose liability on HMOs for providing substandard medical care are not preempted by ERISA or FEHBA. 00-665 Pet. App. B51-B52, B80. The court held that certain other provisions of the Act are preempted by ERISA. *Id.* at B72-B75 (anti-indemnity and anti-retaliation provisions preempted). And, in the ruling pertinent to the principal question presented in these petitions, the court held that the Texas law's provisions for independent review of medical necessity decisions are also preempted by ERISA. *Id.* at B67, B70. See also *id.* at B15 (concluding that the Texas provisions for independent review are not saved as insurance regulation because, in the court's view, they were not limited to entities within the insurance industry). The court held that no provisions of the Act are preempted by FEHBA. *Id.* at B77-B80.

c. The Fifth Circuit affirmed in relevant part. The Secretary of Labor appeared as amicus curiae in the court of appeals, arguing, *inter alia*, that the external review provisions are not preempted by ERISA.

As an initial matter, the court of appeals agreed with the district court that the liability provisions of the state law are not preempted, but disagreed with the lower court's conclusion that ERISA preempts the anti-retaliation and anti-

indemnity provisions. 00-665 Pet. App. A7-A11. The court then addressed the validity of the independent review provisions in light of Section 514(a), 29 U.S.C. 1144(a), ERISA's express preemption provision. It concluded that the IRO provisions "relate to" ERISA plans within the meaning of Section 514(a), reasoning that those provisions "include determinations by managed care entities as to coverage, not just negligent decisions by a physician," and thus fall "squarely within the ambit of ERISA's preemptive reach." 00-665 Pet. App. A13.

Applying the factors articulated by this Court in *UNUM Life Insurance Co.* v. *Ward*, 526 U.S. 358 (1999), the court of appeals further determined that the IRO provisions "regulate[] insurance" within the meaning of ERISA's insurance saving clause in Section 514(b)(2)(A) of the Act, 29 U.S.C. 1144(b)(2)(A). 00-665 Pet. App. A13-A15. The court first concluded that the IRO provisions satisfy the common-sense test of insurance regulation because they apply only to entities acting as insurers, and, by mandating a contract term that includes certain procedural requirements, they go to the heart of the relationship between the insured and the insurer. *Id.* at A14-A15. "For the same reasons," the court held, "the provisions satisfy the second and third prongs of the McCarran-Ferguson [Act]" test of what constitutes an insurance regulation, see *UNUM*, 526 U.S. at 373-374, although they "probably do not meet the first factor of reallocating the risk between the insured and insurer." 00-665 Pet. App. A15.[1]

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[1] The court of appeals thus disagreed with the district court's conclusion that the state law failed to meet the third factor, which requires that a law be limited to the insurance industry, because it applied to managed care entities as well as more traditional insurers. 00-665 Pet. App. A14-A15. The court of appeals reasoned that the relevant inquiry is whether the law is limited in its application to entities (including HMOs) acting as insurers. *Id.* at A14. It found the Texas law to be so limited. *Ibid.*

The court's analysis did not stop there, however. Instead, it held that "even if the provisions would otherwise be saved, they may nonetheless be preempted if they conflict with a substantive provision of ERISA." 00-665 Pet. App. A15. Based on its view that *Pilot Life Insurance Co.* v. *Dedeaux*, 481 U.S. 41 (1987), held that ERISA's judicial enforcement scheme in Section 502(a) of the Act, 29 U.S.C. 1132(a) (1994 & Supp. V 1999), "preempts not only directly conflicting remedial schemes, but also supplemental state law remedies," the court reasoned that "the saving clause does not operate if the state law at issue creates an alternative remedy for obtaining benefits under an ERISA plan." 00-665 Pet. App. A15. The court concluded that the "quasi-administrative procedure" in the IRO provisions for reviewing denials of benefits provides "an alternative mechanism" for obtaining the identical relief offered by Section 502(a), and as such conflicts with Section 502(a). *Id.* at A15-A16.

Additionally, the court concluded that the independent review provisions are preempted by FEHBA because they "specifically conflict with the administrative remedy provided by the Office of Personnel Management concerning benefits disputes." 00-665 Pet. App. A17.

d. On petition for rehearing, the panel rejected the State's argument that this Court's intervening decision in *Pegram* v. *Herdrich*, 530 U.S. 211, 237 (2000), which held that mixed medical-eligibility decisions made by an HMO through its physicians are not fiduciary decisions under ERISA, cast doubt on the court's conclusion that the external review provisions are preempted. The court stated that *Pegram* does not lead to the conclusion that "every conceivable state law claim survives preemption so long as it is based on a mixed question of eligibility and treatment." 00-665 Pet. App. D2-D3.

2. *Rush Prudential.* Section 4-10 of the Illinois Health Maintenance Organization Act, 215 Ill. Comp. Stat. Ann. 125/1-1 *et seq.* (West 1993 & Supp. 2001), requires an HMO to

submit to binding independent review whenever there is a disagreement between a patient's primary care physician and an HMO over whether a course of treatment is medically necessary. 00-1021 Pet. App. 6a. The *Rush Prudential* case arises from such a disagreement.

a. Respondent Debra C. Moran is a beneficiary under a medical benefit plan sponsored by her husband's employer and governed by ERISA. 00-1021 Pet. App. 3a. Respondent Rush Prudential HMO (Rush) provides "medically necessary" benefits under the plan. *Ibid.*

Moran first sought treatment in 1996 from her Rush-affiliated primary care physician, Dr. LaMarre, for pain, numbness, loss of function, and decreased mobility in her right shoulder. 00-1021 Pet. App. 3a. Moran then consulted at her own expense with Dr. Julia Terzis, an out-of-network surgeon. *Id.* at 3a-4a. Dr. Terzis recommended that Moran undergo a surgical microneurological procedure to correct her problem. *Id.* at 4a. Two Rush-affiliated thoracic surgeons confirmed Dr. Terzis's diagnosis, but recommended a standard and less complicated (and less expensive) surgical procedure. *Id.* at 4a, 5a. Moran, however, supported by Dr. LaMarre, unsuccessfully sought approval from Rush for the procedure recommended by Dr. Terzis. *Id.* at 5a.

b. In January 1998, Moran made a written demand on Rush to comply with the Illinois independent review provision. 00-1021 Pet. App. 6a. When Rush did not act on her request, Moran filed a suit in state court to require Rush to submit to binding independent review. *Id.* at 6a-7a. Rush removed the action to federal district court on the ground that the claim was completely preempted by ERISA, but the district court remanded. *Id.* at 6a-7a, 34a. In the meantime, Moran opted to undergo the surgery by Dr. Terzis in February 1998. *Id.* at 6a. She submitted the bill for $94,841.27 to Rush. *Ibid.*

c. On remand, the state court ordered Rush to submit to independent review. 00-1021 Pet. App. 7a, 36a. The inde-

pendent reviewing physician determined that surgery was medically necessary, and he reported that he would have used a procedure similar to that used by Dr. Terzis. *Id.* at 7a-8a. Rush, however, again denied Moran's claim for reimbursement on the ground that Dr. Terzis's surgery was not medically necessary. *Id.* at 8a.

d. Moran then sought a state court order requiring Rush to reimburse her for the surgery. 00-1021 Pet. App. 8a, 36a. Rush again removed the action to district court, and the district court held that the removal now was appropriate. *Id.* at 36a-43a. The court held that Moran's suit to compel reimbursement for surgery was properly characterized as a claim for benefits under Section 502(a)(1)(B) of ERISA, and as such was completely preempted by the federal law. *Id.* at 41a-42a. Moreover, the court concluded that the state-law claim was not saved from preemption as an insurance regulation under Section 514(b)(2)(A) of ERISA, 29 U.S.C. 1144(b)(2)(A), because the Illinois HMO statute's IRO provision did not transfer or spread the policyholder's risk. 00-1021 Pet. App. 42a-43a.

On Rush's motion for summary judgment, the court concluded that Moran's only viable claim was a claim for benefits under the plan itself. 00-1021 Pet. App. 54a. The court concluded, however, that Rush did not abuse its discretion or act arbitrarily in denying Moran's benefit claim. *Id.* at 56a. The court noted that the plan granted Rush "the broadest possible discretion" in making benefit determinations, and also specified the method by which Rush would evaluate medical necessity determinations. *Ibid.* Because Rush used the specified evaluation method and relied on the opinions of three consulting physicians in making its determination, the court granted summary judgment to Rush. *Id.* at 56a-58a.

e. The Seventh Circuit reversed. The court agreed with the district court that Moran's claim was properly characterized as a claim for benefits under Section 502(a)(1)(B) and

therefore was properly removed to federal court. 00-1021 Pet. App. 13a.

Turning to Rush's preemption defense, the court adopted much of the reasoning set forth by the Secretary of Labor in an amicus brief in support of Moran. The court concluded that the state external review law "relates to" ERISA plans because it "has an effect on how benefit determinations are made." 00-1021 Pet. App. 16a. The court then determined, however, that the external review provision is a state law that "regulates insurance" and therefore falls within ERISA's insurance saving clause. *Id.* at 16a-17a. The court found that Section 4-10 satisfies the "common sense" test of insurance regulation because the independent review provision "is directed at the HMO industry as insurers." *Id.* at 17a. The court also stated that the "common sense" test is satisfied because the terms of the independent review provision "are substantive terms of all insurance policies in Illinois by operation of law," *ibid.*, and are therefore "'integral' to the insurer/insured relationship," *id.* at 18a (quoting *UNUM*, 526 U.S. at 374-375). The court reasoned that, because the independent review provision "changes the bargain between insurer and insured" and "is limited to entities within the insurance industry," it "satisfies the second and third *McCarran-Ferguson* factors." *Id.* at 18a (quoting *UNUM*, 526 U.S. at 374); see also *id.* at 16a (citing McCarran-Ferguson Act, 15 U.S.C. 1011 *et seq.*). Citing this Court's decision in *UNUM*, see *id.* at 18a n.3, the court noted that it therefore need not decide whether the Illinois provision transfers or spreads risk—the third McCarran-Ferguson factor. *Ibid.*

The court next examined whether Section 4-10 is preempted as in conflict with Section 502(a) of ERISA, 29 U.S.C. 1132(a) (1994 & Supp. V 1999), under this Court's decision in *Pilot Life Insurance Co.* v. *Dedeaux*, *supra*. 00-1021 Pet. App. 19a. Although the court recognized that the Fifth Circuit reached a contrary conclusion in con-

sidering the "quite similar" provision of Texas Law in *Montemayor*, *ibid.*, the Seventh Circuit concluded that "§ 4-10 of the Illinois HMO Act cannot be characterized as creating an alternative remedy scheme that conflicts with § 502(a)." *Id.* at 21a. Instead, the court concluded that the independent review provisions of the Illinois HMO statute are incorporated into each participant's insurance contract, and accordingly a suit "to enforce the HMO Act's provisions is simply a suit to enforce the terms of the plan—precisely the sort of suit that is contemplated by § 502(a)(1)(B) 'to enforce rights' and 'to recover benefits' under the plan." *Ibid.* Viewed in that light, the court continued, Section 502(a)(1)(B) remains the "sole launching ground" for enforcement of the state law provision, which simply "adds to the contract, by operation of law, an additional dispute resolving mechanism." *Id.* at 21a, 22a. Therefore, the court concluded that unlike the state common law doctrine of general applicability held preempted in *Pilot Life*, the independent review provision of the Illinois HMO Act imposes state-mandated insurance contract terms of the kind that were held in *UNUM* to be saved as insurance regulation. *Id.* at 23a.

The court circulated its decision to the full court for consideration of the desirability of rehearing en banc in light of the conflict between its decision and that of the Fifth Circuit in *Montemayor*. 00-1021 Pet. App. 23a n.7. Although the court declined to order rehearing en banc, Judge Posner, joined by three other judges, dissented from the denial of rehearing en banc. *Ibid.* In Judge Posner's view, "[t]he panel's decision creates a square conflict with" the Fifth Circuit's decision. *Id.* at 24a. He argued, *inter alia*, that the Illinois external review provision "establishes a system of appellate review of benefits decisions that is distinct from the provision in ERISA for suits in federal court to enforce entitlements conferred by ERISA plans." *Id.* at 25a. In his view, imposition of that scheme would improperly transform

the contractual suits envisioned by ERISA in Section 502(a)(1) into suits "for judicial review of the independent physician's decision." *Id.* at 26a.

DISCUSSION

At least thirty-seven states and the District of Columbia have enacted laws that require HMOs to provide some form of independent review of benefit denials. See 00-665 Pet. 27 n.24 (citing statutes). Those state laws vary considerably. The question whether they are preempted in light of ERISA's express preemption provision in Section 514, 29 U.S.C. 1144, and its exclusive provision for civil actions in Section 502(a), 29 U.S.C. 1132(a) (1994 & Supp. V 1999), is an important one. Moreover, the Fifth Circuit's decision in *Montemayor* holding that enforcement of the Texas independent review law is preempted conflicts with the Seventh Circuit's decision in *Rush Prudential* that a substantially similar Illinois law is not preempted and may be enforced.

Nonetheless, further review of the principal question presented by these cases at this time is not warranted. In the last Congress, the Senate and the House of Representatives each passed a bill that would have required, as a matter of federal law, that HMOs provide independent external review. Although no bill on the subject was ultimately enacted into law, new bills have been introduced on the subject in the current Congress, and the President has recently endorsed one of them. Each of the primary bills now under consideration would require, as a matter of federal law, that HMOs provide independent external review, although other aspects of the external review provisions in each of the bills (including the extent to which they would supersede state law) vary. If either of those bills becomes law, it would substantially limit the continuing importance of the issue presented by these cases. At this time, with Congress actively considering the various alternatives, it would be appropriate for this Court to defer to the possibility of a

comprehensive legislative resolution of the important social policy issues bound up in the principal question presented in these cases.

1. a. These cases present the question whether ERISA preempts the application of state statutes providing for independent, external review of decisions made by HMOs to deny medical coverage provided under ERISA plans. As petitioners in No. 00-665 point out, at least 37 States and the District of Columbia have enacted statutory provisions in recent years purporting to entitle their citizens to such review. The provisions vary substantially in a variety of respects. 00-665 Pet. 27 n.24. A review of the cited provisions indicates that most of them generally require the regulated entity to comply with the determination reached by the independent reviewer. A great many individuals obtain their HMO health coverage through ERISA plans. Accordingly, the question whether ERISA preempts state independent review statutes potentially affects the broad enforceability of those statutes, and it therefore is a question of substantial importance to many States and their citizens.

b. As Judge Posner recognized in his dissent from denial of rehearing en banc in *Rush Prudential*, the Seventh Circuit's decision in that case conflicts with the Fifth Circuit's decision in *Montemayor*. 00-1021 Pet. App. 25a.

The scope of the Texas and Illinois laws is in pertinent part identical. As explained by the Fifth Circuit, the Texas law "allow[s] a patient who has been denied coverage [by an HMO] to appeal to an outside organization," and it "requires" that the HMO "'comply' with the independent review organization's determination of medical necessity." 00-665 Pet. App. A13. The Illinois law in *Rush Prudential* "requires HMOs to submit to an independent physician review when there is a disagreement over whether a course of treatment is medically necessary," and if "the independent reviewer determines that the treatment is necessary, the

HMO is required under [the Illinois statute] to cover the treatment." 00-1021 Pet. App. 1a-2a.

Analyzing the two laws under ERISA, both courts of appeals concluded that they "relate to" ERISA plans within the meaning of ERISA's express preemption provision, 29 U.S.C. 1144(a). 00-665 Pet. App. A13 (Texas law is "squarely within the ambit of ERISA's preemptive reach."); 00-1021 Pet. App. 16a (Illinois law "squarely falls within ERISA's preemption clause."). Both courts of appeals also concluded that the state independent review laws "regulate[] insurance" and therefore fall within the scope of ERISA's insurance saving clause, 29 U.S.C. 1144(b)(2)(A). See 00-665 Pet. App. A15 (Texas law "meet[s] the common sense test of the saving clause" and "satisf[ies] the second and third prongs of the McCarran-Ferguson test."); 00-1021 Pet. App. 17a-18a (Illinois law "'regulates insurance' under a common sense understanding" and "satisfies the second and third *McCarran-Ferguson* factors."). At that point, however, the two courts parted company.

The Fifth Circuit in *Montemayor* held that, although the Texas law falls within the insurance saving clause, it nonetheless is preempted because it conflicts with Section 502(a) of ERISA, 29 U.S.C. 1132(a) (1994 & Supp. V 1999). The court stated that the Texas law does not "create a cause of action for the denial of benefits." 00-665 Pet. App. A15. But the court held that it does "create[] an alternative mechanism through which plan members may seek benefits due them under the terms of the plan." *Ibid.* In the Fifth Circuit's view, this Court's decision in *Pilot Life* established that "the saving clause does not operate if the state law at issue creates an alternative remedy for obtaining benefits under an ERISA plan." *Ibid.* On that basis, the court concluded that "the independent review provisions conflict with ERISA's exclusive remedy and cannot be saved by the saving clause." *Id.* at A16. See also *id.* at D6 (Texas law is "plainly a state regime for reviewing benefit decisions and

not a system for implementing a mandated term of insurance regulating a minimal standard of care.").

The Seventh Circuit, by contrast, held that the Illinois provision "cannot be characterized as creating an alternative remedy scheme that conflicts with § 502(a)." 00-1021 Pet. App. 21a. The court concluded that "[r]ather than providing an alternative remedy for Ms. Moran to recover benefits, [the Illinois law] simply establishes an additional internal mechanism for making decisions about medical necessity and identifies who will make that decision in those instances when the HMO and the patient's primary care physician cannot agree on the medical necessity of a course of treatment." *Id.* at 21a-22a. Therefore, "a suit by [Moran] to enforce the [statute's] provisions is simply a suit to enforce the terms of the plan—precisely the sort of suit that is contemplated by § 502(a)(1)(B) 'to enforce rights' and 'to recover benefits' under the plan." *Id.* at 21a.[2] Accordingly, while the Fifth Circuit had held the independent review provisions of the Texas statute preempted, the Seventh Circuit held that the Illinois statute is enforceable.[3]

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[2] To be sure, the *Rush Prudential* case involves a claim by a plan beneficiary for reimbursement of medical expenses after they had been incurred, while *Montemayor* involves a pre-enforcement challenge by insurers to a Texas state law that applies only to ex ante claims for the provision of medical services that the HMO has denied and not claims for reimbursement for services already provided outside the HMO. See 00-665 Pet. 4 n.4. But the Seventh Circuit did not rely on the fact that the case before it involved a claim for reimbursement, rather than for the provision of medical care, and the conclusion that the Illinois statute is not preempted as applied to an ex ante claim for medical services would appear to follow *a fortiori* from the Seventh Circuit's conclusion that the Illinois law is not preempted as applied to an ex post claim for reimbursement. Accordingly, it seems clear under the Seventh Circuit's decision that the Illinois statute is enforceable in the circumstances in which the Texas statute was held by the Fifth Circuit to be unenforceable.

[3] Although it comes to the Court in a somewhat different procedural posture, we see no reason that *Rush Prudential* would provide a better vehicle than *Montemayor* if this Court were to grant review. Petitioners in *Rush Prudential* intimate that because that case arose in the factual setting of a suit by a participant, it presents a more appropriate case for review than *Montemayor*, which involves a facial challenge to the state law. 00-1021 Pet. 20 & n.12. On the other hand, the Texas scheme at issue in *Montemayor* is embodied in a more detailed statutory scheme, which could aid this Court's review. At bottom, "the issue is one of law" in both cases that does not turn on factual distinctions. 00-1021 Pet. App. 24a (Posner, J., dissenting from the denial of hearing en banc).

2. Although there is a two-circuit conflict with respect to the preemption under the current ERISA provisions of mandatory independent review provisions, this Court need not—and in our view should not—grant further review in either case. Primarily, that is because Congress is actively considering legislation that would limit the ongoing importance of the question presented because it would, if enacted, substantially affect the scope of independent review of HMO decisions under ERISA plans and the scope of permissible state-law involvement in that subject. Questions regarding independent review of HMO decisions present serious issues of social and medical policy. Those issues should, if possible, be debated and decided in a legislative—not judicial—forum. Because Congress is currently engaged in precisely that debate, this Court should not grant certiorari to consider the question presented at this time.

a. In the 106th Congress, the House of Representatives and the Senate each passed a version of the so-called "patients' bill of rights" legislation. The Senate bill included a new federal mandate that a group health plan generally must "permit a participant or beneficiary * * * access to an independent external review with respect to an adverse coverage determination concerning a particular item or service" if the coverage was denied as not medically necessary and certain other conditions are satisfied. S. 1344, 106th Cong., 1st Sess. § 121(a) (1999) (adding new Section 503(e) to ERISA); see 145 Cong. Rec. S8623 (daily ed. July 15, 1999).

State laws that address independent review of HMO decisions would have generally continued to be analyzed for preemption under ERISA's preemption provision and its substantive provisions. The House bill similarly included a federal mandate that a group health plan or health insurance plan must "provide for an external appeals process" of any coverage decision that "involves a medical judgment." H.R. 2990, 106th Cong., 1st Sess. § 1103(a)(1) and (2)(A)(ii) (1999); see 145 Cong. Rec. H9523 (daily ed. Oct. 7, 1999). State independent review laws would have been preempted if they either failed to satisfy ERISA Section 514 or if they "prevent[ed] the application of a requirement of [ERISA]." See H.R. 2990, *supra*, § 1152(a)(1) and (2).

b. This year, two major bills have been introduced in Congress that would again address independent review of HMO decisions. S. 889, 107th Cong., 1st Sess. (2001), introduced by Senators Frist, Breaux, and Jeffords, would provide generally that HMOs and other health carriers "shall provide * * * participants and beneficiaries * * * with access to an independent external review for any denial of a claim for benefits" that satisfies certain conditions. *Id.* § 131(a) (adding new Section 503B(a) to ERISA). The bill specifies the independent review procedure in some detail, and it further specifies that the States "may provide for the designation or selection of qualified external review entities." *Ibid.* (adding new Section 503B(h)(1)(B)). Otherwise, the bill provides that "[n]othing in this [portion of the bill] shall be construed to affect or modify the provisions of section 514 of [ERISA] with respect to group health plans." *Id.* § 151(a)(2). The President has recently stated that he supports S. 889. See White House Office of Communications, Statement by the President, 2001 WL 513452 (May 15, 2001).

S. 283, introduced by Senator McCain and 13 other Senators, provides that an HMO "shall provide * * * participants, beneficiaries, and enrollees * * * with access to an independent external review for any denial of a claim for

benefits" that satisfies certain conditions. S. 283, 107th Cong., 1st Sess. § 104(a) (2001). It also specifies in some detail the procedures that would have to be employed in providing the independent review. S. 283 contains a number of preemption provisions that address the continuing effect of state law, § 152, including a provision that state independent review laws would generally remain applicable so long as they did not "prevent the application" of the federal provisions, § 152(b).

c. The two major bills introduced during the current Congress, like the ones that the Senate and the House of Representatives passed during the last Congress, would each institute a new federal mandate for HMOs to submit to independent external review of decisions based on medical necessity. They would therefore address the subject matter of the Texas and Illinois statutes at issue in *Montemayor* and *Rush Prudential*.

There are, of course, significant differences in the bills, including differences in the scope of independent review, the incidents of that federally mandated review, and the remaining scope permitted for state laws in the area. Since each of the bills is comprehensive legislation, each also contains numerous and varying other provisions addressing HMOs and other subjects. But the bills suggest that with respect to external review, there is a significant consensus that some form of federally mandated external review is desirable. Thus, insofar as the underlying question in this case is whether HMOs in Texas or Illinois must provide binding independent external review of their decisions, legislation actively being considered by Congress at this time would both address that question on a nationwide basis and substantially alter the nature and analysis of whatever preemption issues may remain in this area.

In *Pegram* v. *Herdrich*, 530 U.S. 211 (2000), this Court addressed a comparably far-reaching claim that called into question the incentive systems that HMOs may utilize. The

Court noted that the claim turned on "judgment[s] about socially acceptable medical risk," which "would * * * necessarily turn on facts to which courts would probably not have ready access." *Id.* at 221. The Court noted that "a debatable social judgment [is] not wisely required of courts unless for some reason resort cannot be had to the legislative process," with its "preferable forum for comprehensive investigations and judgments of social value, such as optimum treatment levels and health-care expenditure." *Ibid.* Such resort to the legislative forum is now occurring with respect to the question of how to design a suitable structure of independent review of HMO health-care decisionmaking. Accordingly, it would be appropriate for this Court to defer review of the principal question presented in these cases until Congress has had the chance to produce a legislative resolution of the important social policy issues at stake.

d. Finally, a number of other factors suggest that review of the principal question presented in these cases may be deferred at the present time while Congress considers pending legislative proposals.

First, although 37 States and the District of Columbia have enacted independent review laws, the two cases here are, to our knowledge, the only cases to date in which the issue of ERISA preemption has been litigated. That suggests that resolution of the question of whether and to what extent such laws are preempted is not at this point so urgent from a nationwide perspective that it requires immediate resolution by this Court. Moreover, although the Fifth Circuit has held that ERISA preempts state laws that require HMOs that furnish health care to ERISA plan members to provide for independent review and has specifically invalidated the relevant provisions of Texas law, nothing in the Fifth Circuit's decision or in its interpretation of ERISA bars HMOs from choosing to provide such review, either as provided by state law or according to other standards, in order to attract new members, provide assurance to their

existing members, and perhaps furnish some protection against liability. The Fifth Circuit's decision therefore will not necessarily have the effect of eliminating all forms of independent external review for ERISA participants and beneficiaries, even in Texas or other States in that circuit.

Second, if Congress fails to enact a law addressing the subject of independent review in the near future and if the application of state laws addressing the subject proves to be problematic for the covered entities, the prevalence of state laws in the area will provide an opportunity for the preemption issue to be litigated afresh, and this Court therefore would likely have an opportunity to address the conflict in the circuits in the future. On the other hand, if Congress does enact independent review legislation, the nature of the preemption questions raised by state laws on the subject is likely to change dramatically.[4]

Third, the Fifth Circuit in *Montemayor* addressed the State's claim that this Court's decision in *Pegram*—which held that mixed medical-eligibility decisions made by HMO physicians are not fiduciary decisions under ERISA—"cast doubt" on the court's conclusion that the Texas independent review provision is preempted. 00-665 Pet. App. D2. The court stated that it did "not read *Pegram* to entail that every

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[4] If review were granted, the Court might also find it necessary to address questions concerning the relationship between the ERISA insurance saving clause, 29 U.S.C. 1144(b)(2)(A), and the scope of preemption required by ERISA's exclusive remedy provision, 29 U.S.C. 1132(a) (1994 & Supp. V 1999). See *Pilot Life Ins. Co.* v. *Dedeaux*, *supra*; *UNUM Life Ins. Co.* v. *Ward*, 526 U.S. 358, 376 n.7 (1999). That issue may have far-reaching consequences, since it may affect the enforceability of many state insurance regulations (including perhaps even those that provide for liability for insurers) insofar as they apply to insured ERISA plans. Those far-reaching implications suggest that this Court ought not address that issue in a case in which the crucial issue—the availability of independent review to those covered by HMOs—may be resolved on wholly different grounds by Congress.

conceivable state law survives preemption so long as it is based on a mixed question of eligibility and treatment." *Id.* at D2-D3. The Seventh Circuit in *Rush Prudential* did not discuss any analogous argument, perhaps because *Pegram* was decided after the case was briefed. Nonetheless, the *Pegram* argument rejected by the Fifth Circuit would likely be advanced in this Court if further review were granted in either of these cases. See 00-665 Pet. 24-27. The Court would then perhaps find it necessary to address that question, since it goes to the logically antecedent question whether the state law "relates to" ERISA plans, and therefore is within the scope of ERISA's preemption provision at all, regardless of the application of ERISA's insurance saving clause.

In the relatively short time since this Court decided *Pegram*, the federal courts of appeals and state courts have had little opportunity to address the question of what effect, if any, *Pegram*'s discussion of ERISA's fiduciary responsibilities has on ERISA preemption analysis, especially in the context of independent review statutes.[5] The answer to that question could be of very broad significance.[6] If this Court defers review of the principal question presented in

[5] See *Pappas* v. *Asbel*, 768 A.2d 1089 (Pa. 2001) (*Pegram* requires conclusion that ERISA does not preempt state negligence claim against HMO whose physician refused to permit referral to non-network hospital); *Pryzbowski* v. *U.S. Healthcare*, 245 F.3d 266 (3d Cir. 2001) (relying in part on *Pegram* to conclude that state-law claim against HMO for injuries from delays in approving referrals completely preempted).

[6] If this Court's analysis in *Pegram* leads to the conclusion that ERISA does not preempt state laws concerning medical necessity decisions made by managed care entities in the context of ERISA plans, then that conclusion would apparently apply to self-funded as well as insured plans. It could also have implications for the scope of permissible state-law suits against HMOs arising out of such medical necessity decisions. In those respects, the question concerning the effect, if any, of *Pegram* on ERISA preemption analysis could have very broad implications.

these cases, it will enable the lower federal courts and state courts to explore the connection between *Pegram* and ERISA preemption analysis more thoroughly in the first instance. Insofar as this Court finds it necessary to address that issue in a future case, it would then have the benefit of a fuller development of the issue in the lower federal and state courts.[7]

4. The Fifth Circuit also held that the Texas independent review provisions are preempted "under general conflict principles" insofar as they apply to FEHBA plans. Regulations of the Office of Personnel Management (OPM) establish a detailed administrative procedure for review by OPM of denials of benefits by FEHBA plans, 5 C.F.R. 890.105-890.106, followed by review of OPM's decision under the Administrative Procedure Act, 5 U.S.C. 701 *et seq.*, in federal court. See 5 C.F.R. 890.107. State laws (even those regulating insurance, see 5 U.S.C. 8902(m)(1) (1994 & Supp. V 1999))[8] may neither add to the benefits provided under

[7] Respondents in *Montemayor* argue that review is not warranted because "[t]he effect of [new claims processing regulations promulgated by the Department of Labor] on the issue of ERISA's preemption of state external review laws has yet to be evaluated by any lower federal court." 00-665 Br. in Opp. 25. The new regulations, however, provide that "[n]othing in this section shall be construed to supersede any provision of State law that regulates insurance, except to the extent that such law prevents the application of a requirement of this section," 29 C.F.R. 2560.503-1(k)(1), and specifically provide that state external review procedures do not "prevent the application of" any federal requirements. See 29 C.F.R. 2560.503-1(k)(2) ("[A] State law regulating insurance shall not be considered to prevent the application of a requirement of this section merely because such State law establishes a review procedure to evaluate and resolve disputes involving adverse benefit determinations under group health plans so long as the review procedure is conducted by a person or entity other than the insurer, the plan, plan fiduciaries, the employer, or any employee or agent of any of the foregoing.").

[8] FEHBA's preemption provision states that "[t]he terms of any contract under this chapter which relate to the nature, provision, or extent

FEHBA plans nor supplement the federal administrative remedy. The Seventh Circuit did not address any FEHBA preemption question, nor has that question been addressed by any other court of appeals. Petitioners in *Montemayor* present little discussion or analysis of the FEHBA issues in the case. See 00-665 Pet. 27 n.23 (noting simply that "FEHBA preemption * * * entails a 'relates to' analysis"). Accordingly, further review of the Fifth Circuit's determination that the Texas independent review provisions are preempted by FEHBA is not warranted.

CONCLUSION

The petitions for writs of certiorari should be denied.

Respectfully submitted.

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of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law * * * *which relates to health insurance or plans* * * * to the extent that such law or regulation is inconsistent with such contractual provisions." 5 U.S.C. 8902(m)(1) (1994 & Supp. V 1999) (emphasis added).

00-1021 (20)

In The

Supreme Court of the United States

RUSH PRUDENTIAL HMO, INC.,

Petitioner,

v.

DEBRA MORAN and STATE OF ILLINOIS,

Respondents.

On Petition For Writ Of Certiorari To The Unites States Court Of Appeals For The Fifth Circuit

MOTION FOR LEAVE TO FILE AMICUS CURIAE BRIEF and BRIEF OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS AS AMICUS CURIAE IN SUPPORT OF PETITION FOR WRIT OF CERTIORARI

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MOTION FOR LEAVE TO FILE AMICUS CURIAE BRIEF

The National Association of Insurance Commissioners (NAIC) respectfully moves this Court, pursuant to Rule 37.2(b), for leave to file a brief as an amicus curiae in this case in support of the Petition for a Writ of Certiorari, and in support of its motion states:

1. Counsel of record for NAIC attempted to obtain the consent of all parties to the filing of an amicus curiae brief by NAIC by contacting the parties' counsel of record.

2. The Petitioner, Rush Prudential HMO, has consented to the filing of an amicus curiae brief by NAIC through its counsel of record, John G. Roberts, Jr., Hogan & Hartson, L.L.P.

3. The Respondent, State of Illinois, has consented to the filing of an amicus curiae brief by NAIC through its counsel of record, Deborah L. Ahlstrand, Office of the Attorney General.

4. The Respondent, Debra Moran, has denied NAIC's request for consent.

5. NAIC has a strong interest in this case as set out fully in the brief submitted with this motion.

WHEREFORE, premises considered, the National Association of Insurance Commissioners respectfully moves this Court for leave to file a brief as amicus curiae.

Respectfully submitted,

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INTEREST OF AMICUS CURIAE[1]

The National Association of Insurance Commissioners (NAIC) is a non-profit corporation comprised of the chief insurance regulators in each state, four territories and the District of Columbia. The NAIC assists these officials in the pursuit of fundamental insurance regulatory objectives, including: (1) maintaining and improving state regulation in a responsive and efficient manner; (2) maintaining the reliability of insurance business with respect to financial solidity and guarantees against loss; and (3) ensuring fair, just and equitable treatment of policyholders and claimants.[2]

The issue before this Court implicates the NAIC's objectives because it addresses whether the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001 *et seq.* (1999), preempts state independent review laws that regulate insurance within the meaning of ERISA's saving clause, § 514(b)(2)(A).

The NAIC adopted the Health Carrier External Review Model Act (Model Act), Model No. 75, *I NAIC Model Laws, Regulations and Guidelines* (2000), on October 4, 1999. Generally, the Model Act provides for independent review of health carrier coverage decisions based on medical judgment. By adopting this Model Act, the NAIC declared that the independent review of certain claims determinations furthers the NAIC mission – to ensure the fair, equitable and just treatment of insurance consumers.[3]

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[1] Counsel for a party did not author this brief in whole or in part. No person or entity, other than this Amicus Curiae, made a monetary contribution to the preparation and submission of this brief.

[2] NAIC Constitution, Article II. Mission Statement, *I NAIC Proceedings*, 1997, at iv.

[3] *Id.*

This Court should affirm insurance regulators' ability to protect insurance consumers by adopting the rationale of the Seventh Circuit's decision in *Moran v. Rush Prudential HMO, Inc.*, 230 F.3d 959 (7th Cir. Oct. 19, 2000), *petition for cert. filed* (U.S. Dec. 22, 2000) (No. 00-1021), or alternatively, adopting the Second Circuit's rationale in *Franklin H. Williams Ins. Trust v. Travelers Ins. Co.*, 50 F.3d 144 (2d Cir. 1995).

SUMMARY OF ARGUMENT

The issues before this Court in *Rush Prudential HMO, Inc. v. Debra C. Moran, et al.* 00-1021 are identical to those at issue in *Montemayor v. Corporate Health, Ins. Co.*, No. 00-665.[4] The NAIC filed a Brief as Amicus Curiae in Support of the Petition to Grant a Writ of Certiorari in *Corporate Health*, which fully sets forth the reasons why this Court should grant the petition in that case. Many of the arguments raised in the NAIC amicus brief in *Corporate Health* apply equally in the instant case. The NAIC refers this Court to the NAIC amicus brief in *Corporate Health* for a full review of the NAIC arguments that also apply in support of the petition in *Moran*.

The Seventh Circuit holding in *Moran v. Rush Prudential*, 230 F.3d 959 (2000), cannot be reconciled with the Fifth Circuit's holding in *Corporate Health*. The courts in *Corporate Health* and *Moran* came to opposite conclusions regarding whether the independent review law at issue created an alternative enforcement mechanism to ERISA § 502 and was therefore preempted by ERISA.

Independent review laws like the one at issue in the petition are laws of great public importance. Thirty-eight states plus the District of Columbia have enacted independent review laws. It is critical that this Court validate

[4] *Corporate Health Ins. v. Dep't of Ins.*, 215 F.3d 526 (5th Cir. 2000), *petition for cert. filed*, 69 U.S.L.W. 3455 (U.S. Oct. 24, 2000) (No. 00-665).

state independent review laws, which protect consumers from conflicts of interest in the administration of health insurance coverage.

This Court should not revisit the issue of whether state independent review laws regulate insurance within the meaning of ERISA's saving clause § 514(b)(2)(A). The Seventh Circuit in *Moran* and the Fifth Circuit in *Corporate Health* both held correctly that the state independent review laws were within the insurance saving clause.

This Court should affirm the rationale of the Seventh Circuit and hold that state independent review laws merely add terms to insurance contracts, which are enforceable through suits under ERISA. Alternatively, if this Court should find that state independent review laws create a remedy or enforcement mechanism that supplements § 502 of ERISA, this Court should hold that the laws are not, nevertheless, preempted. This Court should revisit its opinion in *Pilot Life v. Dedeaux*, 481 U.S. 41 (1987), and clarify that, by its plain language, ERISA's saving clause, § 514(b)(2)(A), limits the preemptive effect of § 502.

ARGUMENTS

A. The Seventh Circuit decision in *Moran* and the Fifth Circuit decision in *Corporate Health* conflict as to whether state independent review laws provide an alternative enforcement mechanism to ERISA § 502.

Texas and Illinois have enacted very similar independent review laws. Both provide for independent physician review of coverage determinations made by managed care organizations, based on whether a covered service is medically necessary.[5] Both independent review

[5] Tex. Ins. Code art. 20A.12A; 21.58A § 6(c); 21.58A § 6A; 20A.09(e), and 21.58A § 6(b) (West 2000) and 215 Ill. Comp. Stat. 125/4-10 (2000).

laws require that the plan comply with the decision of the independent reviewer.[6]

The laws differ most significantly in the level of detail provided in the independent review laws. The Texas independent review law includes a comprehensive description of the independent review procedure and the utilization review procedures that form the basis for the independent review.[7] The Illinois independent review law does not contain a similar description of the independent review procedures or preliminary procedures prior to the independent review. The laws also differ in the kinds of decisions that are eligible for independent review. The Texas law limits review to concurrent and prospective denials based on medical necessity.[8] The Illinois law requires independent review of disputes between a primary care physician and the Health Maintenance Organization regarding the medical necessity of a covered service.[9]

In 1999, however, the Illinois Legislature adopted the Managed Care Reform and Patient Rights Act.[10] This Act contains provisions that expand and further define the Illinois independent review procedure contained in Section 4-10.[11] Similar to the description of the preliminary

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[6] Tex. Ins. Code art. 21.58A § 6A(3) and 215 Ill. Comp. Stat. 125/4-10.

[7] Tex. Ins. Code art. 21.58A and 21.58C.

[8] Tex. Ins. Code art. 21.58A § 2(20).

[9] 215 Ill. Comp. Stat. 125/4-10.

[10] 215 Ill. Comp. Stat. 134/1 *et seq.* (2000).

[11] "Compliance with this Act's appeals procedures shall satisfy a health care plan's obligation to provide appeal procedures under any other State law or rules." 215 Ill. Comp. Stat. 134/45. "Health maintenance organizations are subject to the provisions of the Managed Care Reform and Patient Rights Act." 215 Ill. Comp. Stat. 125/5-3.6.

appeal of a utilization review decision, which is the underpinning of the Texas independent review law, Section 45 details the procedures for obtaining a preliminary appeal, the denial of which is subject to independent review. Section 45 also supplies the details as to timeframes for the independent review. This level of detail is similar to that in the Texas law.[12] The differences between Section 4-10 in the Illinois law and the Texas independent review law do not lessen the conflict between the Fifth Circuit and Seventh Circuit decisions. The essential conflict remains – whether ERISA preempts state laws that create a procedural right to independent review.[13]

Both the Fifth Circuit and the Seventh Circuit held that the state independent review laws regulate insurance within the meaning of the saving clause. However, the Fifth Circuit and the Seventh Circuit reached opposite conclusions regarding whether the state independent review laws were preempted by ERISA.[14] The Seventh Circuit acknowledged that its decision created a direct conflict with the Fifth Circuit and circulated its opinion to

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[12] For a comparative chart of 38 state independent review laws, plus the District of Columbia, including the Texas and Illinois laws, see NAIC, *External Grievance Review Procedures*, Oct. 1, 2000 (*available in* www.naic.org/1whatsnew/).

[13] This more detailed independent review law is not at issue in *Moran*, therefore, the Texas law at issue in *Corporate Health* may provide this Court with the best vehicle for resolving whether ERISA preempts state independent review laws. *See infra* part E.

[14] A more comprehensive discussion of the conflict as to whether state independent review laws provide an alternative enforcement mechanism to ERISA § 502 is contained in the Brief of NAIC as Amicus Curiae in Support of Petition for Writ of Certiorari, *Corporate Health* (No. 00-665) at 2-7.

the active members of the court in accordance with Circuit Rule 40(e).[15] The dissent to the rehearing en banc similarly recognized the conflict with the Fifth Circuit.[16]

The Fifth Circuit determined that the Texas independent review law was preempted because it conflicted with the remedies of § 502 by creating an alternative procedure for obtaining benefits due under an ERISA plan.[17] The Fifth Circuit, citing *Pilot Life*, emphasized that § 502 preempts not only directly conflicting remedial schemes, but also supplemental state law remedies.[18]

According to the Seventh Circuit, the Illinois independent review law does not provide an alternative enforcement mechanism in conflict with ERISA § 502.[19] The Illinois independent review law merely adds a supplemental "internal" procedure to the insurance contract that is used to make a medical necessity decision in the event that the HMO and a patient's primary care physician disagree.[20] The Seventh Circuit observed that the determination of the reviewing physician would be enforced under § 502(a)(1)(B), and therefore the independent review law alters the plan itself, rather than the mechanism to enforce the plan.[21]

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[15] *Moran*, 230 F.3d at 972 n. 7.

[16] *Id.* at 973.

[17] *Corporate Health*, 215 F.3d at 538-539 (citations omitted).

[18] *Id.*

[19] *Moran*, 230 F.3d at 971.

[20] *Id.* at 971-972.

[21] *Id.*

B. *Moran* Raises Compelling Issues of Great Public Importance.

1. The resolution of conflicts regarding the validity of state independent review laws are of great public importance.

Independent review laws are particularly important[22] because they are an example of state insurance laws enacted in response to consumer concerns about the decisions made by managed care plans involving their health care.[23] Independent review laws were adopted in the states in the wake of decreased consumer confidence in the health care system and managed care in particular.[24] An insurance regulator's primary responsibility is to protect the interests of insurance consumers,[25] and independent review is heralded as being "a fair, impartial and usually expeditious way to resolve disputes."[26]

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[22] A more comprehensive discussion of the importance of resolving conflicts regarding state independent review laws is contained in the Brief of NAIC as Amicus Curiae in Support of Petition for Writ of Certiorari, *Corporate Health* (No. 00-665) at 7-12.

[23] "[External review programs] are meant to address concerns about managed care incentives that might lead to inappropriate denial of care, and to help restore public confidence in managed care." Karen Pollitz, Geraldine Dallek and Nicole Tapay, Institute for Health Care Research and Policy, Georgetown University, *External Review of Health Plan Decisions: An Overview of Key Program Features in the States and Medicare*, Nov. 1998, at 1, 7 [hereinafter *External Review of Health Plan Decisions*].

[24] *Managed Care Regulation and Oversight in Nine States*, Issue Brief, National Governor's Association for Best Practices, June 28, 2000, at 2, 3.

[25] NAIC, *A Tradition in Consumer Protection*, 1998, at 1.

[26] *External Review of Health Plan Decisions*, *supra* note 23, at 1.

To date, 38 states plus the District of Columbia have enacted independent review laws. The Kaiser Family Foundation updated its November 1998 study of independent review laws in May 2000 documenting a doubling in the number of such state laws.[27]

Through the enactment of independent review laws, state legislatures have expressed the judgment that insurers, at least in certain circumstances, do not deserve deference when they are engaged in medical decision-making to determine insurance coverage.[28] Entrusted by ERISA with the regulation of insurance, the legislatures have determined that only a person free of conflicts should be permitted to make final decisions of such delicacy, discretion, and life or death importance. State independent review laws are intended to improve the quality of care provided by the plan, and consumers benefit from the knowledge that an independent, unbiased review of a health plan's decision is available.[29]

2. State laws that regulate insurance and add an enforcement mechanism or other remedy to those provided by ERISA § 502 are an important part of the regulation of insurance reserved for the states in § 514(b)(2)(A).

The Seventh Circuit in *Moran* held that the Illinois independent review law did not create an alternative enforcement mechanism in conflict with ERISA § 502.

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[27] Geraldine Dallek and Karen Pollitz, Institute for Health Care Research and Policy, Georgetown University, *External Review of Health Plan Decisions: An Update*, May 2000, at 1 [hereinafter *External Review Update*].

[28] See discussion of this Court's decision in *Firestone Rubber v. Bruch*, 498 U.S. 101 (1989) in Brief of NAIC as Amicus Curiae in Support of Petition for Writ of Certiorari, *Corporate Health* (No. 00-665) at 10-12.

[29] *External Review Update supra* note 27.

However, the Fifth Circuit reached the opposite conclusion and held that the Texas independent review law provided a remedy to plan members seeking benefits.[30] Under the Fifth Circuit's rationale, ERISA preempts all such supplemental state remedies, regardless of the application of the saving clause.

This Fifth Circuit rationale directly threatens private parties seeking to enforce certain state insurance laws,[31] and applied broadly, may even call into question the enforcement authority of state insurance regulators.[32] We do not believe the Fifth Circuit's rationale goes so far as to preclude state insurance regulator actions to enforce laws such as those governing unfair claim practices. However, some courts might erroneously fail to distinguish state insurance regulator enforcement actions that result in orders to pay claims, as well as penalties. This Court should grant the Petition for a Writ of Certiorari and affirm insurance regulators' ability to protect insurance consumers by upholding the Seventh Circuit's rationale in *Moran*.

C. The Applicability of the Saving Clause is Not an Issue Worthy of Supreme Court Review.

1. There is no conflict as to whether state independent review laws are saved as laws regulating insurance.

Both the Fifth Circuit in *Corporate Health* and the Seventh Circuit in *Moran* recognized that the independent review laws at issue regulated insurance within the

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[30] *Corporate Health*, 215 F.3d at 539.

[31] *See Kanne v. Connecticut Gen. Life Ins. Co.*, 867 F.2d 489 (9th Cir. 1988).

[32] See discussion of the importance of state insurance laws that provide an enforcement mechanism or other remedy in Brief of NAIC as Amicus Curiae in Support of Petition for Writ of Certiorari, *Corporate Health* (No. 00-665) at 12-13.

meaning of ERISA's saving clause, § 514(b)(2)(A). Contrary to the Assertions of the Petition,[33] and the dissent in *Moran*,[34] there is no legal basis for this Court to question the applicability of the saving clause to state independent review laws. This is an issue about which there is uniformity in the Fifth and Seventh Circuits and no conflicting decisions.

The Fifth Circuit held that the Texas independent review law "meet[s] the common-sense test of the saving clause" and "satisf[ies] the second and third prongs of the McCarran-Ferguson test."[35] The Seventh Circuit likewise held that the Illinois law "regulates insurance under a common sense understanding" and clearly "meets at least two of the McCarran-Ferguson factors."[36] Accordingly, this Court should not disturb the judgment of the circuit courts with respect to this issue.

2. Independent review laws are clearly laws that regulate insurance within the meaning of the saving clause.

Independent review laws are laws that regulate insurance within the meaning of the saving clause. However, the Petition alleges that the Illinois independent review law does not regulate insurance because it applies to all HMOs "whether the HMO is acting as an insurer or merely the administrator of a benefit plan as to which another entity bears the risk." Petition for a Writ of Certiorari (No. 00-1021) at 24. While this Court need not reach this issue, the Illinois law clearly regulates insurance within the meaning of the saving clause.

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[33] Petition for a Writ of Certiorari, *Moran* (No. 00-1021) at 23-25.

[34] *Moran*, 230 F.3d at 973-974.

[35] *Corporate Health*, 215 F.3d at 538.

[36] *Moran*, 230 F.3d at 969.

The application of the Illinois independent review law does not extend to HMOs acting as administrators to self-insured plans.[37] The Illinois independent review law applies to HMOs in their capacity as insurers, regulated under the Illinois HMO Act.[38] Section 4-10 of the Act requires that "[e]ach Health Maintenance Organization" provide a mechanism for independent review. 215 Ill. Comp. Stat. 125/4-10. The definition of a "health maintenance organization" makes clear that the law is intended to apply to HMOs in their capacity as risk bearing entities.[39] The definitions of "organization"[40] and "health care plan"[41] further illustrate that Section 4-10 and the

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[37] Even if this law were to extend to administrators of self-insured plans, this Court should only invalidate the application of this law to self-insured plans. *See FMC Corp. v. Holliday*, 498 U.S. 52, 65 (1990) (holding that the Pennsylvania anti-subrogation law at issue was preempted to the extent it applied to self-insured plans).

[38] 215 Ill. Comp. Stat. 125/1-1 *et seq.* (2000).

[39] " 'Health maintenance organization' means any *organization* formed under the laws of this or another state to provide or arrange for one or more health care plans under a system which causes any part of the *risk of health care delivery* to be borne by the organization or its providers." 215 Ill. Comp. Stat. 125/1-2 (emphasis added).

[40] " 'Organization' means any insurance company, a nonprofit corporation authorized under the Dental Service Plan Act [215 Ill. Comp. Stat. 110/1 *et seq.*] or a Voluntary Health Services Plans Act [215 Ill. Comp. Stat. 165/1 *et seq.*], or a corporation organized under the laws of this state or another state for the purpose of operating one or more health care plans and doing *no other business other that that of a health maintenance organization or an insurance company.*" 215 Ill. Comp. Stat. 125/1-2 (emphasis added).

[41] " 'Health care plan' means any arrangement whereby any organization undertakes to *provide or arrange for or reimburse the cost of basic health care services* from providers selected by the Health Maintenance Organization, and such arrangement

Illinois HMO Act exclusively apply to HMOs engaged in the business of insurance. An HMO that is acting as an administrator for a self-insured plan is clearly beyond the scope of the Illinois law. An administrative services only contract is not an insurance product and is not subject to the Illinois HMO Act.[42]

From a common sense perspective, the Illinois independent review law regulates insurance.[43] A law regulates insurance if it is aimed at the insurance industry. *Pilot Life*, 481 U.S. at 50. The Illinois independent review law specifically applies to HMOs.[44] Illinois regulates

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consists of arranging for or the provision of such health care services as distinguished from mere indemnification against the cost of such services. . . . " 215 Ill. Comp. Stat. 125/1-2. (emphasis added).

[42] In addition, the Illinois Managed Care Reform and Patient Rights Act, 215 Ill. Comp. Stat. 134/1 *et seq.*, which provides details regarding the practical operation of the independent review procedure, contains a definition of "health plan" that specifically excludes self-insured ERISA plans. *See* discussion *supra* at pp. 4-5.

[43] According to this Court, whether a state law "regulates insurance" depends on a "common sense" understanding of insurance regulation. Also relevant are the three "guideposts" used to determine the "business of insurance" under the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.* The three factors are: (1) whether the law has the effect of transferring or spreading a policyholder's risk; (2) whether the law is an integral part of the policy relationship between the insurer and the insured; and (3) whether the law is limited to entities within the insurance industry. *Unum v. Ward*, 526 U.S. 358, 373-375 (1999) (citations omitted).

[44] "Each Health Maintenance Organization shall provide a mechanism for the timely review by a physician . . . in the event of a dispute between the primary care physician and the Health Maintenance Organization regarding the medical necessity of a covered service proposed by a primary care physician. . . . " 215 Ill. Comp. Stat. 125/4-10.

HMOs as insurers.[45] This Court also understands that HMOs are insurers. In *Pegram v. Herdrich*, 120 S. Ct. 2143, 2149 (2000), this Court described the evolution of traditional fee for service insurance to HMOs and recognized that HMOs are risk-bearing organizations that function much like traditional insurers. Therefore, a law that "regulates HMOs" clearly regulates insurance from a "common sense" perspective.[46]

The three McCarran-Ferguson guideposts reinforce the common sense understanding of the Illinois independent review law as a law that regulates insurance. First, the law has the effect of transferring or spreading a policyholder's risk. The Petitioner asserts that Section 4-10 "does not have the effect of spreading a policyholder's risk" [see, Petition For Writ of Certiorari, at 24]. According to the Secretary of Labor in its amicus brief before the Seventh Circuit in *Moran*, the Illinois independent review law spreads risk by requiring an HMO to use a certain procedure for determining which claims to pay. This procedure is an integral part of risk-spreading because it determines which risks will be spread and in what manner.[47] Indeed, HMOs factor these risks into setting the premiums for their contracts, which is a central element of risk spreading.

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[45] *See In The Matter of Estate of MedCare HMO*, 998 F.2d 436 (7th Cir. 1993).

[46] *See Washington Physicians Serv. Ass'n v. Gregoire*, 147 F.3d 1039 (9th Cir. 1998). *But see O'Reilly v. Ceuleers*, 912 F.2d 1383 (11th Cir. Fla. 1999) (distinguishable because the ERISA plan at issue was not an insured plan; the HMO was acting as an administrator; and the court relied on dicta in this Court's 1982 decision, *Arizona v. Maricopa County Medical Society*, 457 U.S. 332, 339 n. 7 (1982), which has since been clarified by this Court's opinion in *Pegram*, 120 S. Ct. at 2149.

[47] Brief of the Secretary of Labor as Amicus Curiae, *Moran* (No. 99-2574) (*available in* www.dol.gov/pwba/public/pubs/ab/moranfin.txt) at 8.

The remaining two McCarran-Ferguson factors are also plainly satisfied. The Illinois independent review law is an integral part of the policy relationship between the insurer and the insured and is limited to entities within the insurance industry. Similar to the notice-prejudice rule at issue in *Ward*, the Illinois independent review law goes to the heart of the insurer-insured relationship by dictating the process whereby the HMO decides whether benefits are owed to the insured.[48] The Illinois independent review law is also similar to the mandated benefit law at issue in *Metropolitan Life Insurance Company v. Massachusetts*, 471 U.S. 724 (1985). In *Metropolitan Life*, this Court held that the Massachusetts mandated benefit law regulated insurance because it directly controlled the terms of insurance contracts by requiring a particular provision in the contract. *Id.* at 724. Accordingly, the Illinois independent review law provides an insured with a contractual right to an independent grievance process.

The dissent from the denial of rehearing en banc in *Moran* challenged the Seventh Circuit's conclusion that the Illinois independent review law becomes a substantive term in all insurance policies because an action to enforce the decision of an independent reviewer can be brought under § 502 as an action to enforce the terms of the plan.[49] According to the dissent, the Illinois independent review law "invites states to evade the preemptive force of ERISA simply by deeming its regulations of ERISA plans to be plan terms."[50] The dissent contends that the Illinois independent review law could not both regulate insurance and become a part of the ERISA plan enforceable in federal court.[51]

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[48] *See* 526 U.S. at 374-375.

[49] 230 F.3d 959, 971.

[50] *Id.* at 974.

[51] *Id.*

What the dissent characterizes as "evasion" of ERISA's preemptive force is really the proper and intended application of the saving clause – to "save" state laws that regulate insurance by altering the terms of the insurance contract. This Court has recognized that disuniformities inevitably result from the application of the saving clause, since insured plans in different jurisdictions will provide different coverage in order to comply with varying state insurance laws.[52] However, if plans were able to displace any state regulation by inserting a contrary term in plan documents, it would "virtually read the saving clause out of ERISA."[53] This Court has "repeatedly held that state laws mandating insurance contract terms are saved from preemption."[54] In *Ward*, the notice-prejudice rule provided the relevant rule of decision in a § 502 suit to recover benefits due under the terms of the plan.[55]

An agreement with an HMO providing benefits to an ERISA plan becomes part of the ERISA plan. This Court in *Pegram* explained that an HMO that contracts with an employer to provide benefits is not an ERISA plan, "but the agreement between an HMO and an employer who pays the premiums may [ ] provide elements of a plan by setting out rules under which beneficiaries will be entitled to care."[56] In short, the HMO is not the ERISA plan, but the HMO provides the terms of the ERISA plan

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[52] *Ward*, 526 U.S. at 376 n. 6.

[53] *Id.* at 376.

[54] *Id.* at 375-376, citing *Metropolitan Life*, 471 U.S. at 758 ("Massachusetts' mandated-benefit law is a 'law which regulates insurance' and so is not preempted by ERISA as it applies to insurance contracts purchased for plans subject to ERISA.")

[55] 526 U.S. 358, 376-377.

[56] 120 S. Ct. at 2151 (citations omitted).

through the insurance contract.[57] Therefore, when an employer decides to purchase insurance rather than self-insure an ERISA plan, state insurance laws continue to apply to the insurer and an ERISA plan indirectly.[58]

The dissent in *Moran* also asserts that the Illinois independent review law adds procedural burdens and increases "costs in the administration of ERISA plans [that] will shrink benefits and deter some employers from offering health insurance at all."[59] The issue of cost is irrelevant to whether a law regulates insurance within the meaning of ERISA's saving clause, § 514(b)(2)(A). Mandated benefit laws add costs to the plans that choose to purchase insurance rather than self-insure. This fact did not prevent this Court from deciding in *Metropolitan Life* that the Massachusetts mental health law regulated insurance within the meaning of the saving clause. Similarly, procedural protections like the notice-prejudice rule at issue in *Ward* add costs by causing claims to be paid that would otherwise be denied. A law mandating independent review is no different.

Moreover, there is no evidence that independent review laws have a negative effect on the marketplace. The November 1998 Kaiser Family Foundation study cites several studies conducted to estimate indirect costs in complying with external review laws, such as the cost of care associated with overturned denials.[60] Price Waterhouse estimated costs for California's external review law

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[57] An ERISA plan is only "bound by state insurance regulations insofar as they apply to the plan's insurer." *FMC Corp.*, 498 U.S. at 61.

[58] *FMC Corp.*, 498 U.S. 52, 64 (1990).

[59] 230 F.3d at 973-974.

[60] *External Review of Health Plan Decisions, supra* note 23 at 46.

to be three cents per member per month.[61] The Congressional Budget Office Study estimated the potential costs of a federally mandated independent review law to be 0.3% of premium.[62] The 1998 Kaiser Family Foundation study reported that according to an industry representative, "whatever costs a plan might incur from external review, they are modest and a 'well spent business expense' in light of the contribution to improved customer relations he believes external review generates".[63]

3. The deemer clause does not apply in this case.

The Petitioner in *Moran* references the district court's decision to deny reconsideration.[64] The district court was not persuaded to review its earlier decision in light of this Court's decision in *Ward*. Instead, the district court erroneously determined that the Illinois independent review law was preempted under the deemer clause. The deemer clause is not applicable in this case. The deemer clause operates to shelter self-insured ERISA plans from state insurance regulation.[65] In *Ward*, this Court dismissed the deemer clause argument because a self-insured plan was not at issue.[66] Neither does *Moran* involve a self-insured plan. The Illinois independent review law applies to HMOs in their capacity as insurers. According to this Court, an ERISA plan may be regulated indirectly through the regulation of its insurer.[67]

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[61] *Id.* at 47.

[62] *Id.*

[63] *Id.* at 46.

[64] Petition for Writ of Certiorari, *Moran* (No. 00-1021) at 9 n. 3.

[65] *Ward*, 526 U.S. 358, 367 n. 2 (citations omitted).

[66] *Id.*

[67] *FMC Corp.*, 498 U.S. at 64.

D. The Seventh Circuit Decision Reaches the Correct Result; Independent Review Laws do not Provide Remedies that Conflict with § 502, and Even if They are Remedies, They are Subject to the Saving Clause.

The Courts of Appeals for the Fifth Circuit and the Seventh Circuit reached opposite conclusions regarding whether ERISA preempts state independent review laws. According to the Seventh Circuit, the independent review law regulated insurance within the meaning of the saving clause, and did not provide an alternative enforcement mechanism in conflict with ERISA § 502. This Court should uphold the Seventh Circuit's rationale and find that ERISA does not preempt state independent review laws.

However, the Fifth Circuit in *Corporate Health* reached the opposite conclusion with respect to Texas's independent review law. The Fifth Circuit, citing *Pilot Life*, emphasized that § 502 preempts not only directly conflicting remedial schemes, but also supplemental state law remedies.[68] The Fifth Circuit determined that, despite regulating insurance within the meaning of the saving clause, the Texas independent review law was preempted because it created an alternate procedure for obtaining benefits that conflicted with the remedies of § 502.[69]

The Fifth Circuit's decision is incorrect.[70] State independent review laws do not create an alternate enforcement mechanism to § 502.[71] Even if this Court finds that

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[68] *Corporate Health*, 215 F.3d at 358-359.

[69] *Id.* at 539 (citations omitted).

[70] A comprehensive discussion of the merits issues raised by *Corporate Health* and *Moran* is contained in the NAIC Brief as Amicus Curiae in Support of Petition for Writ of Certiorari, *Corporate Health* (No. 00-665) at 13-20. See also *Franklin Trust*, 50 F.3d 144.

[71] *See* Brief of NAIC as Amicus Curiae in Support of Petition for Writ of Certiorari, *Corporate Health* (No. 00-665) at 14-16.

state independent review laws do provide for an alternate enforcement mechanism, the laws are saved from preemption under ERISA § 514(b)(2)(A).[72]

E. The Fifth Circuit's decision in *Corporate Health* case is the preferable vehicle for the resolution of the issue presented in both *Corporate Health* and *Moran*.

Corporate Health and *Moran* raise the identical issue for review before this Court – whether ERISA preempts state independent review laws. This Court should grant and hold the Petition for a Writ of Certiorari in *Moran*. The Illinois independent review law at issue in this case is not the only law providing the right to independent review in Illinois. The Illinois legislature enacted the Managed Care Reform and Patient's Rights Act in 1999, which contains an indepe lent review provision.[73] The Managed Care Reform and Patient's Rights Act independent review provision is not at issue in *Moran* and is not presently before this Court.

In addition, the Fifth Circuit's decision in *Corporate Health* conflicts the Seventh Circuit's decision in *Moran* as well as the Second Circuit's decision in *Franklin Trust*.[74]

The second of these conflicts arises out of disparate readings of *Pilot Life*. Because the Fifth Circuit in Corporate Health found that the state independent review law did establish an alternative enforcement mechanism, it reached the question of whether the saving clause could preserve such a mechanism or supplemental remedy from preemption. Thus, *Corporate Health* presents this Court with a clearer

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[72] *Id.* at 16-20.

[73] *See* discussion *supra* at pp. 4-5.

[74] *See* Brief of NAIC as Amicus Curiae in Support of Petition for Writ of Certiorari, *Corporate Health* (No. 00-665) at 6-7.

opportunity to resolve not only whether state independent review laws create alternative enforcement mechanisms to § 502, but also whether the insurance saving clause can preserve from preemption a state law regulating insurance that also creates a remedy supplemental to ERISA § 502. *Moran* does not directly present this Court with the same opportunity to revisit *Pilot Life*.

For these reasons, the NAIC suggests that the Texas independent review law at issue in *Corporate Health* is the preferable vehicle for this Court to decide whether state independent review laws are preempted under ERISA. The Petition for a Writ of Certiorari in *Moran* should be granted and held in light of this Court's decision in *Corporate Health*.

CONCLUSION

For the foregoing reasons, the Petition for a Writ of Certiorari should be granted and the case held.

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IN THE

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RUSH PRUDENTIAL HMO, INC.,
Petitioner,

v.

DEBRA C. MORAN AND STATE OF ILLINOIS,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

SUPPLEMENTAL BRIEF FOR PETITIONER

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SUPPLEMENTAL BRIEF FOR PETITIONER[1]

The Solicitor General agrees that there is a stark conflict between the circuits as to whether the "independent review" provisions of state laws governing HMOs are preempted by ERISA, and that this question "is an important one." Br. for the United States as Amicus Curiae at 9. *See id.* at 10 ("the question whether ERISA preempts state independent review statutes * * * is a question of substantial importance to many States and their citizens"); *id.* ("the Seventh Circuit's decision in [*Rush Prudential*] conflicts with the Fifth Circuit's decision in *Montemayor*").

Yet the Solicitor General recommends against a grant of certiorari because legislative proposals pending in Congress

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[1] Petitioner's Rule 29.6 Statement appears at Pet. ii.

might—if passed and signed by the President—forestall the need for review here. *Id.* at 9, 13. This Court should not stay its hand in favor of the mere *potential* for legislative resolution of this critical question, over which the circuits are in conflict *now*.

As respondent acknowledges, the legislative proposals to which the Solicitor General refers are the subject of "partisan disagreement." Opp. at 2; *see also* Pet. 21. The Solicitor General likewise recognizes that although the Senate and the House of Representatives each passed a bill in the last Congress requiring HMOs to provide independent external review of benefit denials, "no bill on the subject was ultimately enacted into law." Br. for United States at 9. Indeed, the Solicitor General concedes that there are "significant differences" in the bills currently pending in Congress, including "differences in the scope of independent review, the incidents of that federally mandated review, and the remaining scope permitted for state laws in the area." *Id.* at 15; *see id.* at 9.

The bills currently pending are also comprehensive legislation, containing "numerous and varying other provisions addressing HMOs and other subjects." *Id.* at 15. Thus, even if, as the Solicitor General suggests, there is consensus that "some form of federally mandated external review is desirable," *id.*, the Solicitor General can hardly offer any assurance—or even hazard a wager—that a comprehensive healthcare bill containing such a provision will emerge from the sausage factory that is the legislative process in the foreseeable future. Far from it, in fact: the "other subjects" addressed by the comprehensive legislation are the subject of

intense debate.[2] *See* Petition for Certiorari, *Thomas* v. *Outboard Marine Corp.*, No. 85-1735, at 17 (Solicitor General sought certiorari despite "congressional agreement" on legislation addressing same issue, where there existed "substantial controversy between the House and Senate over other provisions," rendering the "prospects for and timing of final passage" of the bill "uncertain").

This Court typically turns aside the suggestion that it should not decide an issue of national import in a case that satisfies the stringent requirements for certiorari, *see* S. Ct. Rule 10(a), simply because Congress is concurrently considering the issue. *See* Br. for Respondent in *BMW of North America, Inc.* v. *Gore*, No. 94-896, at 14-15 (noting that "Congress has considered, as part of the legislative debate, virtually all the proposals that BMW and its amici seek to constitutionalize," and that "[t]o date, the House of Representatives and the Senate have each enacted legislation [imposing federal constraints on punitive damage awards] that is being reconciled in conference"). That is an appropriate response. It should come as no surprise that legal issues of national importance are also issues of interest to Congress. For this Court generally to refrain from deciding issues that Congress may—but may not—address would impede this Court in its historic task of resolving live circuit conflicts such as the one created by the Seventh Circuit's decision here.

Legislative proposals, even those being "actively consider[ed]" by Congress, Br. for United States at 9, are still just that: proposals. Particularly where such proposals are

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[2] *See, e.g., Health Care Issues Await the New President*, Boston Globe, Jan. 16, 2001, at F1 ("For almost half a decade, Congress has been wrestling with different versions of the so-called Patients' Bill of Rights."); Patient Care, Vol. 35, Issue 7 (Apr. 15, 2001), at 2135 (noting "vigorous debate in Congress on one issue: whether patients should be allowed to sue their HMOs").

incorporated into a massive legislative undertaking that will doubtless be the subject of intense partisan debate and may languish at the end of this Congress, just as at the end of the last, the suggestion that this Court should stay its hand is not convincing. It is also a particularly cavalier response for the Solicitor General to offer, given the very real practical problems the current conflict poses for companies, insurers, HMOs, state regulators, and employees. *See, e.g.*, Br. of the National Association of Insurance Commissioners as Amicus Curiae in Support of Petition 7-9. This Court should review the conceded conflict in the courts and decide this question of national importance.

CONCLUSION

For the foregoing reasons, and those stated in the petition and reply, the petition for a writ of certiorari should be granted.

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No. 00-1021

IN THE

Supreme Court of the United States

RUSH PRUDENTIAL HMO, INC.,

Petitioner,

v.

DEBRA C. MORAN AND STATE OF ILLINOIS,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

JOINT APPENDIX

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PETITION FOR CERTIORARI FILED DECEMBER 22, 2000
CERTIORARI GRANTED JUNE 29, 2001

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B. Memorandum Opinion and Order of the United States District Court for the Northern District of Illinois (June 9, 1998) 28a

C. Memorandum Opinion and Order of the United States District Court for the Northern District of Illinois (March 24, 1999) 35a

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E. Memorandum Opinion and Order of the United States District Court for the Northern District of Illinois (June 15, 1999) 47a

UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

No. 99-2574

Debra C. Moran,

Plaintiff-Appellant,

v.

Rush Prudential HMO, Inc.,

Defendant-Appellee.

DOCKET ENTRIES

DATE	FILINGS – PROCEEDINGS
6/22/99	Private civil case docketed. [99-2574] [1191139-1] Transcript information sheet due 7/2/99. Appellant's brief due 8/2/99 for Debra C. Moran. Docketing Statement due 6/28/99. (joce)
8/11/99	Filed motion by State of Illinois to intervene because the constitutionality of a state statute has been drawn in question. [1205688-1] [99-2574] (kell)
8/17/99	ORDER issued GRANTING motion to intervene by the State of Illinois because the constitutionality of a state statute has been drawn into question. The clerk of this court is directed to correct the docket to reflect this

	change. Briefing shall proceed in accordance with this court's order dated July 19, 1999. [1205688-1] JKL [99-2574] (land)
10/1/99	Filed 15c appellant's brief by Debra C. Moran. Disk filed. [99-2574] [1220605-1] (patb)
10/1/99	Filed 10c appendix by Appellant Debra C. Moran. [99-2574] [1220606-1] (patb)
10/1/99	Filed 15c appellant's brief by State of Illinois. Disk filed. [99-2574] [1220609-1] (patb)
10/12/99	Filed 15c amicus brief by Amicus Curiae Secretary of Labor. Disk filed. [99-2574] [1223268-1] (patb)
10/15/99	Filed 15c amicus brief by Amicus Curiae AMA, Amicus Curiae IL State Medical, Amicus Curiae American College Leg., per order. Disk filed. [99-2574] [1226286-1] (patb)
2/7/00	Filed 15c appellee's brief by Rush Prudential HMO, per order. Disk filed. [99-2574] [1259637-1] (squi)
2/7/00	Filed 15c amicus brief by Amicus Curiae IL State Chamber, Amicus Curiae Employment Law Council, filed per order. Disk filed. [99-2574] [1259691-1] (patb)
2/7/00	Filed 10c appendix by Amicus Curiae IL State Chamber, Amicus Curiae Employment Law Council. [99-2574] [1259693-1] (patb)

2/22/00	Filed 15c appellant's reply brief by Debra C. Moran. Disk filed. [99-2574] [1263531-1] (kell)
3/23/00	Filed 15c appellant's reply brief by State of Illinois. Disk filed. [99-2574] [1273423-1] (patb)
4/18/00	Case heard and taken under advisement by panel: Circuit Judge Joel M. Flaum, Circuit Judge Kenneth F. Ripple, Circuit Judge Ann C. Williams. [99-2574] [1282027-1] (broo)
4/18/00	Case argued by John P. Schmidt for Appellant State of Illinois, Melinda Sue Kollross for Appellee Rush Prudential HMO, Daniel P. Albers for Appellant Debra C. Moran. [99-2574] [1191139-1] (broo)
6/26/00	Filed Appellant State of Illinois Citation of Additional Authority, per CR 28(e). Dist. [99-2574] [1301953-1] (patb)
6/26/00	Filed Appellee Rush Prudential HMO Citation of Additional Authority, per CR 28(e). Dist. [99-2574] [1302468-1] (patb)
10/19/00	Filed opinion of the court by Judge Ripple. The opinion has been circulated among all judges of this court in regular active service, under Circuit Rule 40(e). A majority of the judges in active service did not wish to rehear the case en banc. Judges Posner, Coffey, Easterbrook and Diane P. Wood voted to grant rehearing en banc. REVERSED. Chief Judge Joel M. Flaum, Circuit Judge Kenneth F. Ripple, Circuit Judge Ann C. Williams.

	Circuit Judge Richard A. Posner, with whom Circuit Judges John L. Coffey, Frank H. Easterbrook, and Diane P. Wood join, dissenting from denial of hearing en banc. [99-2574] [1191139-1] (joce)
10/19/00	ORDER: Final judgment filed per opinion. With costs: y. [99-2574] [1336329-1] (joce)
10/24/00	ORDER: The opinion of this Court issued on 10/19/00 is amended as follows: At slip opinion page 23, footnote 7, add Judge Ilana D. Rovner took no part in the consideration or decision of this matter. [99-2574] [1191139-1] (joce)
11/17/00	MANDATE ISSUED AND ENTIRE RECORD RETURNED. (Contents returned: 3 vol. pleadings; 6 vol. loose pleadings; 1 vol. exhibits) [99-2574] [1191139-1] (cove)
1/2/01	Filed notice from the Supreme Court of the filing of a Petition for Writ of Certiorari. Supreme Court Case No.: 00-1021. [99-2574] [1358598-1] (joce)
7/9/01	Filed order from the Supreme Court GRANTING the Petition for Writ of Certiorari. Supreme Court Case No.: 00-1021. [99-2574] [1414851-1] (joce)

U.S. DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS (CHICAGO)

No. 98-CV-442

Debra C. Moran,

Plaintiff.

v.

Rush Prudential HMO, Inc.,

Defendant.

Filed: 01/26/98
Assigned to: Hon. Suzanne B. Conlon
Referred to: Hon. Ian H. Levin
Demand: $0,000
Nature of Suit: 791
Lead Docket: None
Jurisdiction: Federal Question
Dkt # in Circuit Ct. Cook Co.: is 98 CH 00902
Cause: 29:1132 E.R.I.S.A.-Employee Benefits

DOCKET ENTRIES

DATE	FILINGS – PROCEEDINGS
1/26/98	NOTICE OF REMOVAL by defendant from Circuit Court of Cook County with copy of complaint and motion, case no. 98 CH 902 - Civil cover SHEET - Appearance(s) of Joshua Lee Smith, David Faulkner Schmidt, Joseph J. Hasman as attorney(s) for defendant

(Documents: 1-1 through 1-3) (pw) [Entry date 01/28/98]

4/17/98 MOTION by plaintiff to remand case to the Circuit Court of Cook County; Notice of motion (jmp) [Entry date 04/30/98]

5/11/98 RESPONSE by Rush Prudential HMO to plaintiff's motion to remand case to the Circuit Court of Cook County [9-1]; Notice of filing (jmp) [Entry date 05/12/98]

6/2/98 MEMORANDUM, OPINION, AND ORDER (jmp) [Entry date 06/09/98]

6/2/98 MINUTE ORDER of 6/2/98 by Hon. Suzanne B. Conlon: Plaintiff's motion to remand case to the Circuit Court of Cook County granted [9-1]. This case is remanded to the Circuit Court of Cook County. Enter memorandum opinion and order terminating case. Mailed notice (jmp) [Entry date 06/09/98]

6/2/98 ENTERED JUDGMENT (jmp) [Entry date 06/09/98]

2/12/99 NOTICE OF REMOVAL OF A CIVIL ACTION by Rush Prudential HMO regarding removal complaint [1-1] (Exhibits); Notice of filing (jmp) [Entry date 02/16/99]

2/24/99 ANSWER to plaintiff's first amended complaint by Rush Prudential HMO; Notice of filing (jmp) [Entry date 02/25/99]

3/8/99 SECOND MOTION by Debra C Moran to remand case to Circuit Court of Cook County for lack of subject matter jurisdiction

(Attachment) (Exhibits); Notice of filing (jmp) [Entry date 03/09/99]

3/8/99 MEMORANDUM by Debra C Moran in support of second motion to remand case to Circuit Court of Cook County for lack of subject matter jurisdiction [33-1] (jmp) [Entry date 03/09/99]

3/16/99 RESPONSE by Rush Prudential HMO to motion to remand case to Circuit Court of Cook County for lack of subject matter jurisdiction [33-1] (Exhibits); Notice of filing (jmp) [Entry date 03/17/99]

3/22/99 MEMORANDUM, OPINION, AND ORDER (11) [Entry date 03/24/99]

3/22/99 MINUTE ORDER of 3/22/99 by Hon. Suzanne B. Conlon: Plaintiff's motion to remand and for costs pursuant to 28 U.S.C. 1447(c) is denied. [33-1] Enter Memorandum Opinion and Order. Mailed notice (11) [Entry date 03/24/99]

4/5/99 MOTION by Debra C Moran for leave to file second amended complaint (Exhibits); Notice of motion (jmp) [Entry date 04/09/99] [Edit date 04/09/99]

4/12/99 MINUTE ORDER of 4/12/99 by Hon. Suzanne B. Conlon: Plaintiff's motion for leave to [38-1] file second amended complaint is granted [38-2]. Defendant to file answer to the complaint simultaneously with dispositive motion by 04/23/99. Plaintiff to file response by 05/15/99. Defendant to reply to response

by 05/21/99. Mailed notice (jmp) [Entry date 04/13/99]

4/22/99 MOTION by plaintiff to reconsider based on new authority (Exhibits); Notice of motion. (mk) [Entry date 04/29/99]

4/23/99 ANSWER by defendant Rush Prudential HMO to plaintiff's second amended complaint; Notice of filing. (mk) [Entry date 04/26/99]

4/23/99 MOTION by defendant for summary judgment; Notice of filing. (mk) [Entry date 04/26/99]

4/23/99 MEMORANDUM by Rush Prudential in support of motion for summary judgment [42-1]; Notice of filing. (mk) [Entry date 04/26/99]

5/4/99 RESPONSE by defendant Rush Prudential HMO to plaintiff's motion for reconsideration [46-1]; Notice of filing. (mk) [Entry date 05/05/99]

5/6/99 MINUTE ORDER of 5/6/99 by Hon. Suzanne B. Conlon: Plaintiff Debra Moran's motion for reconsideration based on new authority is denied [46-1]. (See reverse of minute order.) Mailed notice by judge's staff. (mk) [Entry date 05/07/99]

5/24/99 MEMORANDUM by plaintiff in opposition to Rush's motion for summary judgment [42-1]; Notice (hp) [Entry date 05/25/99]

6/3/99 SUPPLEMENT by plaintiff to memorandum in opposition to motion for summary judgment [58-1] (mk) [Entry date 06/10/99]

6/9/99 REPLY by defendant to motion for summary judgment [42-1]; Notice. (mk) [Entry date 06/22/99]

6/14/99 MEMORANDUM, OPINION, AND ORDER (mk) [Entry date 06/15/99] [Edit date 06/15/99]

6/14/99 MINUTE ORDER of 6/14/99 by Hon. Suzanne B. Conlon: Moran's motion to strike Dr. Rosenberg's affidavit and certain exhibits to Rule 12(M) statement [57-1] is denied. The motion for summary judgment [42-1] is granted. Judgment is entered in favor of defendant Rush Prudential HMO, Inc. and against plaintiff Debra C. Moran terminating case. Mailed notices by judge's staff notice (mk) [Entry date 06/15/99]

6/14/99 ENTERED JUDGMENT (mk) [Entry date 06/15/99]

6/21/99 NOTICE OF APPEAL by plaintiff Debra C Moran judgment entered [81-1] from judgment entered [81-1], Scheduling order terminating case [80-1] from Scheduling order terminating case [80-1], motion minute order [80-2] from motion minute order [80-2], order [79-1] from order [79-1], motion minute order [53-1] from motion minute order [53-1], motion minute order [37-1] from motion minute order [37-1], order [36-1] from order [36-1], judgment entered [19-1] from

judgment entered [19-1], Scheduling order This case is remanded to the Circuit Court of Cook County. [18-1] from Scheduling order This case is remanded to the Circuit Court of Cook County. [18-1], Scheduling order terminating case [18-2] from Scheduling order terminating case [18-2], motion minute order [18-3] from motion minute order [18-3], order [17-1] from order [17-1]; Notice of Filing ($105.00 Paid) (ls) [Entry date 06/22/99]

11/20/00 COPY of Order dated 11/16/00 from the 7th Circuit: It is ordered that the motion for stay of mandate is denied. (99-2574) (kf) [Entry date 11/21/00]

11/22/00 CERTIFIED COPY of order from the 7th Circuit: Reversing decision of the District Court [Appeal [85-1]. (99-2574) (ls) [Entry date 11/27/00]

11/22/00 OPINION from the 7th Circuit: Argued 4/18/00; Decided 10/19/00. (99-2574) (ls) [Entry date 11/27/00]

1/18/01 MOTION by plaintiff for entry of judgment, including prejudgment interest and costs (Attachments); Notice (ls) [Entry date 02/02/01]

1/24/01 MINUTE ORDER of 1/24/01 by Hon. Suzanne B. Conlon: Plaintiff's motion for entry of judgment, including prejudgment interest [102-1] and costs is granted [102-2]. Judgment to enter. Mailed notice. (ls) [Entry date 02/02/01]

1/24/01 ENTERED JUDGMENT (ls) [Entry date 02/02/01]

7/2/01 MINUTE ORDER of 7/2/01 by Hon. Ian H. Levin: Defendant's motion to stay ruling on plaintiff's motion for attorneys' fees is granted [113-1]. Plaintiff's amended motion for attorneys' fees [101-1] is stayed pending appeal in the U.S. Supreme Court. Mailed notice. (ls) [Entry date 07/09/01]

IN THE CIRCUIT COURT
OF COOK COUNTY, ILLINOIS,
COUNTY DEPARTMENT,
CHANCERY DIVISION

No. 98 CH 00902

Debra C. Moran,

Plaintiff,

v.

Rush Prudential HMO, Inc.,

Defendant.

Hon. Dorothy Kinnaird

COMPLAINT FOR SPECIFIC PERFORMANCE

NOW COMES the Plaintiff, DEBRA C. MORAN, by and through her attorney, James C. Ten Broeck, and for Complaint against the defendant RUSH PRUDENTIAL HMO, INC., alleges as follows:

1. Defendant is an Illinois corporation doing business and maintaining an office in the County of Cook, State of Illinois.

2. Defendant is a Health Maintenance Organization within the meaning and purview of the "Health Maintenance Organization Act," 215 ILCS 125/1-1 et seq.

3. Defendant issued, for and in consideration of monthly premiums, its Certificate of Group Health Coverage

("Certificate"), a copy which is attached hereto and incorporated herein as Exhibit A.

4. Plaintiff, as spouse of subscriber Paul Moran, was and is at all times pertinent hereto, a Qualified Dependent under the terms of the Certificate and entitled to the benefits thereunder. Attached hereto and incorporated herein as Exhibit B is the Membership Card.

5. Plaintiff has been diagnosed with brachial plexopathy and thoracic outlet syndrome. On October 14, 1997, Dr. Arthur LaMarre, plaintiff's primary care physician, recommended that she be approved to have surgery by Dr. Julia K. Terzis. A copy of said recommendation is attached hereto and incorporated herein as Exhibit C.

6. On October 23, 1997, the coverage for the requested surgery was denied "due to lack of medical necessity per plan certificate for the procedure requested." Copy of denial is attached hereto and incorporated herein as Exhibit D.

7. Plaintiff appealed the denial of coverage, and on November 11, 1997, defendant affirmed its denial of coverage. Copy of affirmance letter is attached hereto and incorporated herein as Exhibit E.

8. Plaintiff appealed the affirmance of denial of coverage to defendant's Membership Advisory Committee. On December 4, 1997, said Committee met and shortly thereafter, issued its written decision again affirming the denial of coverage. Attached hereto and incorporated herein as Exhibit F is said written decision.

9. Plaintiff has thereby exhausted her administrative remedies pursuant to the Certificate.

10. The first week of January, 1998, Ms. Mary Kay Duncan of CCC, Inc. Human Resources Department, the employer of plaintiff's husband, contacted Mr. Dan Engel, an attorney with defendant's legal staff, and requested an independent review of the medical necessity of plaintiff's proposed surgery pursuant to the Health Maintenance

Organization Act, 215 ILCS 125/4-10, a copy of which is attached hereto and incorporated herein as Exhibit G. Mr. Engel responded that he would research the issue and get back to her by January 14, 1998.

11. Despite plaintiff's repeated telephone calls and her written demand of January 14, 1998, a copy of which is attached hereto and incorporated herein as Exhibit H, defendant has failed and refused to comply with said statutory provision.

12. Plaintiff has no adequate remedy at law.

WHEREFORE, Plaintiff prays that the Court order Defendant to agree on the appointment of an independent reviewing physician pursuant to the provisions of said statute, and for such other and further relief as the Court deems meet and proper, and that the Court retain jurisdiction of the matter until the defendant fully complies with said statute, and that plaintiff be awarded her legal costs and fees incurred against defendant.

Signed,

/s/

James C. Ten Broeck
Attorney for Plaintiff
1652 N. Humboldt Blvd.
Chicago, IL 60647
(773) 235-5604

[Filed November 2, 1998]

IN THE CIRCUIT COURT OF COOK COUNTY,
COUNTY DEPARTMENT, CHANCERY DIVISION

NO. 98 CH 00902

DEBRA C. MORAN,

Plaintiff,

v.

RUSH PRUDENTIAL HMO, INC.,

Defendant.

ORDER

THIS CAUSE COMING ON TO be heard on Plaintiff's Motion to Strike the Affidavit of William Pawluk, Plaintiff's Motion for Judgment on the Pleadings, Defendant's Cross-Motion for Judgment on the Pleadings and Defendant's Motion to Strike Plaintiff's Reply Brief Relating to Judgment on the Pleadings; briefs having been filed, arguments heard and the Court being fully advised on the premises:

WHEREFORE, IT IS HEREBY ORDERED that:

1. Plaintiff's Motion to Strike the Affidavit of William Pawluk is granted; the Court will not consider that Affidavit with respect to the Cross-Motions for Judgment on the Pleadings;

2. Defendant's Motion to Strike the Reply Brief of Plaintiff is denied;

3. Defendant's Cross-Motion for Judgment on the Pleadings is denied; and

4. Plaintiff's Motion for Judgment on the Pleadings is granted in part, to the extent that the Court declares the rights of the parties under the Illinois Independent Review Law as set forth herein; specifically, Defendant Rush HMO Prudential HMO is hereby required and ordered under the pertinent statute, 215 ILCS §125/4-10, to provide an independent review of the medical necessity of the surgery Debra Moran had for her conditions of brachial plexopathy and thoracic outlet syndrome; the Court specifically finds that the portion of the independent review statute which requires independent review is not preempted by ERISA; the Court further holds that it is reserving ruling on whether there is or is not preemption of that portion of the statute which requires coverage in the event the independent review determines the covered service to be medically necessary.

5. This case is set for status on December 4, 1998, at 10:00 a.m.

/s/_____
The Honorable Dorothy Kinnaird
Circuit Court Judge

IN THE CIRCUIT COURT
OF COOK COUNTY, ILLINOIS,
COUNTY DEPARTMENT,
CHANCERY DIVISION

No. 98 CH 00902

Debra C. Moran,

Plaintiff,

v.

Rush Prudential HMO, Inc.,

Defendant.

Hon. Dorothy Kinnaird

FIRST AMENDED COMPLAINT

Plaintiff, Debra Moran, by her attorneys, Barnes & Thornburg, for her First Amended Complaint against Defendant Rush Prudential HMO, Inc. states as follows:

1. Defendant is an Illinois corporation doing business and maintaining an office in the County of Cook, State of Illinois.

2. Defendant is a health maintenance organization within the meaning and purview of the "Health Maintenance Organization Act," 215 ILCS §125/1/1 *et seq.*

3. Defendant issued, for and in consideration of monthly premiums, its certificate of group health coverage ("Certificate"), a copy of which is attached hereto and incorporated herein as Exhibit A.

4. Plaintiff, as spouse of subscriber Paul Moran, was and is at all times pertinent hereto, a qualified dependent under the terms of this Certificate and entitled to the benefits thereunder. Attached hereto and incorporated herein as Exhibit B is the Membership Card.

5. The provisions of the Illinois HMO Act, 215 ILCS §125/1-1 *et seq*., including, §125/4-10, are a part of Defendant's Certificate as a matter of law.

6. Defendant also specifically adopted Illinois law as a part of its Certificate by reason of the language of that Certificate at Page 34 of Exhibit A which provides:

> If the provisions of this Certificate do not conform to the requirements of any state or federal law that applies to this Certificate, the Certificate is automatically changed to conform with the requirements of that law.

7. Plaintiff was diagnosed with brachial plexopathy and thoracic outlet syndrome. On October 14, 1997, Dr. Arthur LaMarre, Plaintiff's primary care physician under the Certificate, recommended that she be approved to have surgery by Dr. Julia K. Terzis. A copy of said recommendation is attached hereto and incorporated herein as Exhibit C.

8. On October 23, 1997, the coverage for the requested surgery was denied "due to lack of medical necessity per plan certificate for the procedure requested." A true and correct copy of the denial is attached hereto and incorporated herein as Exhibit D.

9. Plaintiff appealed the denial of coverage and on November 11, 1997, Defendant affirmed its denial of coverage. A true and correct copy of the affirmance letter is attached hereto and incorporated as Exhibit E.

10. Plaintiff appealed the affirmance of denial of coverage to Defendant's Membership Advisory Committee. On December 4, 1997, said Committee met and shortly thereafter, issued its written decision again, affirming the denial of coverage. A true and correct copy of that written decision is attached hereto and incorporated herein as Exhibit F.

11. Plaintiff has exhausted her administrative remedies pursuant to the Certificate.

12. Plaintiff has repeatedly requested Defendant provide an independent review of the medical necessity of Plaintiff's surgery pursuant to the Certificate and the HMO Act, 215 ILCS §125/4-10.

13. Defendant refused to provide a proper utilization review of Plaintiff's surgery by an independent review of the medical necessity of Plaintiff's proposed surgery pursuant to the Certificate and the HMO Act, 215 ILCS §125/4-10, and Defendant has failed and refused to comply with said Certificate and statutory provision.

14. The Illinois HMO Act, 215 ILCS §125/4-10 provides:

> §4-10(a) Medical Necessity - Dispute Resolution - Independent Second Opinion. Each Health Maintenance Organization shall provide a mechanism for the timely review by a physician holding the same class of license as the primary care physician, who is unaffiliated with the Health Maintenance Organization, jointly selected by the patient (or the patient's next of kin or legal representative if the patient is unable to act for himself), primary care physician and the Health Maintenance Organization in the event of a dispute between the primary care physician and the Health Maintenance Organization regarding the medical necessity of a covered service proposed by a primary care physician. In the event that the reviewing physician determines the covered service to be medically necessary, the Health Maintenance Organization shall provide the covered service. Future contractual or

employment action by the Health Maintenance Organization regarding the primary care physician shall not be based on the physician's participation in this procedure.

15. The Illinois HMO Act, 215 ILCS §125/4-10, is an Illinois state statute which regulates insurance.

16. Plaintiff filed a first Complaint in this action on January 23, 1998.

17. Defendant answered that first Complaint on July 10, 1998.

18. Plaintiff moved for judgment on the pleadings on the first Complaint on August 14, 1998.

19. On November 2, 1998, this Court entered a partial judgment on the pleadings for Plaintiff, ruling that the portion of the HMO Act which requires independent review is not preempted by ERISA and ordering Defendant to provide the independent review.

20. The independent review was done by Dr. A. Lee Dellon. Both parties agreed to Dr. Dellon as the Independent Review physician.

21. On December 15, 1998, Dr. Dellon submitted his Independent Review report, a true and correct copy of which is attached as Exhibit G. The Independent Review report concludes that Plaintiff's surgery was medically necessary.

22. Despite Dr. Dellon's Independent Review which found the surgery medically necessary, Defendant still refuses to provide a proper utilization review, refuses to abide by the Certificate and the statute, and refuses to pay for the covered surgery.

23. Despite the recommendation of Plaintiff's primary care physician that Defendant approve Plaintiff's surgery, Defendant still refuses to provide a proper utilization review,

refuses to abide the Certificate and the statute, and refuses to pay for the covered surgery.

24. Despite the recommendation of the Medical Director of CENTRA, the Joint Venture contracting partner of Defendant which provides physician and hospital services for Defendant, that Defendant approve Plaintiff's surgery, Defendant still refuses to provide a proper utilization review, refuses to abide by the Certificate and the statute, and refuses to pay for the covered surgery.

25. Plaintiff is within the class of persons whom the HMO Act, 215 ILCS §125/4-10 was intended to protect.

26. As a direct and proximate result of Defendant's failure and refusal to provide a proper utilization review, its refusal to abide by the Certificate, and its refusal to abide by the statute, Plaintiff was forced to:

(a) obtain the covered surgery and related medical treatment herself;

(b) take loans against the 401(k) retirement plans of her husband;

(c) take personal loans;

(d) personally incur the expense of the requested surgery and follow up care in the total amount of $94,841.27.

27. Plaintiff obtained and paid for the requested surgery and follow-up care herself. Therefore, Plaintiff does not seek a benefit by this action because she has already received the requested medical care.

28. Plaintiff has no adequate remedy at law.

WHEREFORE, Plaintiff Debra Moran prays for a final judgment ordering that Defendant Rush Prudential HMO, Inc.:

(a) specifically perform and abide by the terms of its policy and the Illinois statute 215 ILCS §125/4-10 and pay

for the expenses of the surgery it was supposed to provide but which it refused to provide;

(b) reimburse Debra Moran in the amount of $94,841.27 for the expenses she incurred as the result of Defendant's refusal to provide a proper utilization review, its refusal to abide by the Certificate, and its refusal to abide by the statute;

(c) pay Debra Moran prejudgment interest on the liquidated sum of $94,841.27;

(d) pay all expenses necessary to clear the personal loans and to clear the loans against the 401(k) retirement plans of Debra Moran's husband; and

(e) such other and further relief as the Court deems just in the circumstances.

By: /s/ Daniel P. Albers
One of the Attorneys on
Behalf of Plaintiff
Debra C. Moran

Daniel P. Albers
BARNES & THORNBURG
200 West Madison - Suite 2610
Chicago, IL 60606
(312) 357-1313
Dated: February 4, 1999

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

No. 98 C 442

Debra C. Moran,

Plaintiff,

v.

Rush Prudential HMO, Inc.,

Defendant.

District Judge Conlon
Magistrate Judge Levin

SECOND AMENDED COMPLAINT

Plaintiff, Debra Moran, by her attorney, Daniel P. Albers, for her Second Amended Complaint against Defendant Rush Prudential HMO, Inc. states as follows:

COUNT I - VIOLATION OF ILLINOIS HMO ACT

1. Defendant is an Illinois corporation doing business and maintaining an office in the County of Cook, State of Illinois.

2. Defendant is a health maintenance organization within the meaning and purview of the "Health Maintenance Organization Act," 215 ILCS §125/1/1 *et seq.*

3. Defendant issued, for and in consideration of monthly premiums, its certificate of group health coverage ("Certificate"), a copy of which is attached hereto and incorporated herein as Exhibit A.

4. Plaintiff, as spouse of subscriber Paul Moran, was and is at all times pertinent hereto, a qualified dependent under the terms of this Certificate and entitled to the benefits thereunder. Attached hereto and incorporated herein as Exhibit B is the Membership Card.

5. The provisions of the Illinois HMO Act, 215 ILCS §125/1-1 *et seq.*, including, §125/4-10, are a part of Defendant's Certificate as a matter of law.

6. Defendant also specifically adopted Illinois law as a part of its Certificate by reason of the language of that Certificate at Page 34 of Exhibit A which provides:

> If the provisions of this Certificate do not conform to the requirements of any state or federal law that applies to this Certificate, the Certificate is automatically changed to conform with the requirements of that law.

7. Plaintiff was diagnosed with brachial plexopathy and thoracic outlet syndrome. On October 14, 1997, Dr. Arthur LaMarre, Plaintiff's primary care physician under the Certificate, recommended that she be approved to have surgery by Dr. Julia K. Terzis. A copy of said recommendation is attached hereto and incorporated herein as Exhibit C.

8. On October 23, 1997, the coverage for the requested surgery was denied "due to lack of medical necessity per plan certificate for the procedure requested." A true and correct copy of the denial is attached hereto and incorporated herein as Exhibit D.

9. Plaintiff appealed the denial of coverage and on November 11, 1997, Defendant affirmed its denial of coverage. A true and correct copy of the affirmance letter is attached hereto and incorporated as Exhibit E.

10. Plaintiff appealed the affirmance of denial of coverage to Defendant's Membership Advisory Committee. On December 4, 1997, said Committee met and shortly thereafter, issued its written decision again, affirming the denial of coverage. A true and correct copy of that written decision is attached hereto and incorporated herein as Exhibit F.

11. Plaintiff has exhausted her administrative remedies pursuant to the Certificate.

12. Plaintiff has repeatedly requested Defendant provide an independent review of the medical necessity of Plaintiff's surgery pursuant to the Certificate and the HMO Act, 215 ILCS §125/4-10.

13. In December, 1997 and January, 1998 Defendant refused to provide a proper utilization review of Plaintiff's surgery by an independent review of the medical necessity of Plaintiff's proposed surgery pursuant to the Certificate and the HMO Act, 215 ILCS §125/4-10, and Defendant has failed and refused to provide independent review or analysis, to comply with the Certificate or to comply with the statutory provision.

14. As a result, Debra Moran was forced to obtain the covered surgery and related medical treatment herself, at her own expense, during the period February 19, 1998 through August, 1998. She obtained the requested surgery and follow-up care herself from Dr. Julia K. Terzis and the surgery and follow-up care were successful.

15. The Illinois HMO Act, 215 ILCS §125/4-10 provides:

> §4-10(a) Medical Necessity - Dispute Resolution - Independent Second Opinion. Each Health Maintenance Organization shall provide a mechanism for the timely review by a physician holding the same class of license as the primary care physician, who is unaffiliated with the Health Maintenance Organization, jointly selected by the patient (or the patient's next of kin or legal representative

if the patient is unable to act for himself), primary care physician and the Health Maintenance Organization in the event of a dispute between the primary care physician and the Health Maintenance Organization regarding the medical necessity of a covered service proposed by a primary care physician. In the event that the reviewing physician determines the covered service to be medically necessary, the Health Maintenance Organization shall provide the covered service. Future contractual or employment action by the Health Maintenance Organization regarding the primary care physician shall not be based on the physician's participation in this procedure.

16. The Illinois HMO Act, 215 ILCS §125/4-1, *et seq.* and §4-10 thereof are Illinois state statutes which regulate insurance.

17. The Illinois HMO Act is a state law which regulates insurance and is exempt from ERISA preemption under 29 U.S.C. §1144(b)(2)(A).

18. The Illinois HMO Act has the effect of transferring or spreading a policyholder's risk.

19. None of the three McCarran-Ferguson criteria for a state law which regulates insurance is necessarily determinative in itself. *Union Labor Life Ins. Co.* v. *Pireno*, 458 U.S. 119, 129, 102 S. Ct. 3002 (1982).

20. Plaintiff filed a first Complaint in this action on January 23, 1998 in the Circuit Court of Cook County.

21. Defendant answered that first Complaint on July 10, 1998.

22. Plaintiff moved for judgment on the pleadings on the first Complaint on August 14, 1998.

23. On November 2, 1998, the Circuit Court of Cook County entered a partial judgment on the pleadings for Plaintiff, ruling that the portion of the HMO Act which

requires independent review is not preempted by ERISA and ordering Defendant to provide the independent review. A true and correct copy of the Court's Order is attached as Exhibit H.

24. The independent review was done by Dr. A. Lee Dellon. Both parties agreed to Dr. Dellon as the Independent Review physician.

25. On December 15, 1998, Dr. Dellon submitted his Independent Review report, a true and correct copy of which is attached as Exhibit G. The Independent Review report concludes that Plaintiff's surgery was medically necessary.

26. Despite Dr. Dellon's Independent Review which found the surgery medically necessary, Defendant still refuses to provide a proper utilization review, refuses to abide by the Certificate and the statute, and refuses to pay for the covered surgery.

27. Despite the recommendation of Plaintiff's primary care physician that Defendant approve Plaintiff's surgery, Defendant still refuses to provide a proper utilization review, refuses to abide the Certificate and the statute, and refuses to pay for the covered surgery.

28. Despite the recommendation of the Medical Director of CENTRA, the Joint Venture contracting partner of Defendant which provides physician and hospital services for Defendant, that Defendant approve Plaintiff's surgery, Defendant still refuses to provide a proper utilization review, refuses to abide by the Certificate and the statute, and refuses to pay for the covered surgery.

29. Plaintiff is within the class of persons whom the HMO Act, 215 ILCS §125/4-1 *et seq.* and §4-10, in particular, were intended to protect.

30. As a direct and proximate result of Defendant's failure and refusal to provide a proper utilization review, its refusal to abide by the Certificate, and its refusal to abide by the statute, Plaintiff was forced to:

(a) obtain the covered surgery and related medical treatment herself;

(b) take loans against the 401(k) retirement plans of her husband;

(c) take personal loans;

(d) personally incur the expense of the requested surgery and follow-up care in the total amount of $94,841.27.

31. Plaintiff obtained and paid for the requested surgery and follow-up care herself. Therefore, Plaintiff does not seek a benefit by this action because she has already received the requested medical care.

32. Plaintiff has no adequate remedy at law.

33. Plaintiff's claim for reimbursement does not demand an interpretation of the term "medical necessity" under the Rush HMO plan, it does not require a determination of the medical necessity of the procedures at issue, and it does not require interpretation of a contract governed by federal law.

WHEREFORE, Plaintiff Debra Moran prays for a final judgment:

(a) remanding this cause to the Circuit Court of Cook County, and ordering Defendant Rush Prudential HMO, Inc. to:

(b) specifically perform and abide by the terms of its policy and the Illinois statute 215 ILCS §125/4-10 and pay for the expenses of the surgery it was supposed to provide but which it refused to provide;

(c) reimburse Debra Moran in the amount of $94,841.27 for the expenses she incurred as the result of Defendant's refusal to provide a proper utilization review, its refusal to abide by the Certificate, and its refusal to abide by the statute;

(d) pay Debra Moran prejudgment interest on the liquidated sum of $94,841.27;

(e) pay all expenses necessary to clear the personal loans and to clear the loans against the 401(k) retirement plans of Debra Moran's husband; and

(f) such other and further relief as the Court deems just in the circumstances.

Pursuant to Federal Rule of Civil Procedure 8(e)(2), and because of the Court's memorandum opinion and order of March 22, 1999 denying Debra Moran's Second Motion to Remand, Debra Moran pleads Counts II through III in the alternative to Count I and hypothetically, in the event the Court finds ERISA preempts Debra Moran's claims under Count I. Debra Moran does so with the intent to preserve her claims set forth in her Second Motion to Remand and the claims of her Amended Complaint and Count I of her Second Amended Complaint, that those claims are not preempted by ERISA.

ALTERNATIVE COUNT II -
ERISA - BREACH OF CONTRACT
AND VIOLATION OF ILLINOIS HMO ACT

Pursuant to 29 U.S.C. §1132(a)(1)(b), Plaintiff Debra Moran pleads alternatively as follows:

1. Defendant is an Illinois corporation doing business and maintaining an office in the County of Cook, State of Illinois.

2. Defendant is a health maintenance organization within the meaning and purview of the "Health Maintenance Organization Act," 215 ILCS §125/1/1 *et seq.*

3. Defendant issued, for and in consideration of monthly premiums, its certificate of group health coverage ("Certificate"), a copy of which is attached hereto and incorporated herein as Exhibit A.

4. Plaintiff, as spouse of subscriber Paul Moran, was and is at all times pertinent hereto, a qualified dependent under the terms of this Certificate and entitled to the benefits thereunder. Attached hereto and incorporated herein as Exhibit B is the Membership Card.

5. The provisions of the Illinois HMO Act, 215 ILCS §125/1-1 *et seq.*, including, §125/4-10, are a part of Defendant's Certificate as a matter of law. *Plumb* v. *Fluid Pump Service*, 124 F.3d 849, 859 (7th Cir. 1997).

6. Defendant also specifically adopted Illinois law as part of its Certificate by reason of the language of that Certificate at Page 34 of Exhibit A which provides:

> If the provisions of this Certificate do not conform to the requirements of any state or federal law that applies to this Certificate, the Certificate is automatically changed to conform with the requirements of that law.

7. Plaintiff was diagnosed with brachial plexopathy and thoracic outlet syndrome. On October 14, 1997, Dr. Arthur LaMarre, Plaintiff's primary care physician under the Certificate, recommended that she be approved to have surgery by Dr. Julia K. Terzis. A copy of said recommendation is attached hereto and incorporated herein as Exhibit C.

8. On October 23, 1997, the coverage for the requested surgery was denied "due to lack of medical necessity per plan certificate for the procedure requested." A true and correct copy of the denial is attached hereto and incorporated herein as Exhibit D.

9. Plaintiff appealed the denial of coverage and on November 11, 1997, Defendant affirmed its denial of coverage. A true and correct copy of the affirmance letter is attached hereto and incorporated as Exhibit E.

10. Plaintiff appealed the affirmance of denial of coverage to Defendant's Membership Advisory Committee. On December 4, 1997, said Committee met and shortly

thereafter, issued its written decision again, affirming the denial of coverage. A true and correct copy of that written decision is attached hereto and incorporated herein as Exhibit F.

11. Plaintiff has exhausted her administrative remedies pursuant to the Certificate.

12. Plaintiff has repeatedly requested Defendant provide an independent review of the medical necessity of Plaintiff's surgery pursuant to the Certificate and the HMO Act, 215 ILCS §125/4-10.

13. In December, 1997 and January, 1998 Defendant refused to provide a proper utilization review of Plaintiff's surgery by an independent review of the medical necessity of Plaintiff's proposed surgery, or pursuant to the Certificate and the HMO Act, 215 ILCS §125/4-10, and Defendant has failed and refused to provide independent review or analysis, to comply with the Certificate or to comply with the statutory provision.

14. As a result, Debra Moran was forced to obtain the covered surgery and related medical treatment herself, at her own expense, during the period February 19, 1998 through August, 1998. She obtained the requested surgery and follow-up care herself from Dr. Julia K. Terzis and the surgery and follow-up care were successful.

15. The Illinois HMO Act, 215 ILCS §125/4-10 provides:

> §4-10(a) Medical Necessity - Dispute Resolution - Independent Second Opinion. Each Health Maintenance Organization shall provide a mechanism for the timely review by a physician holding the same class of license as the primary care physician, who is unaffiliated with the Health Maintenance Organization, jointly selected by the patient (or the patient's next of kin or legal representative if the patient is unable to act for himself), primary care physician and the Health Maintenance Organization in the event of a dispute between the primary care physician

and the Health Maintenance Organization regarding the medical necessity of a covered service proposed by a primary care physician. In the event that the reviewing physician determines the covered service to be medically necessary, the Health Maintenance Organization shall provide the covered service. Future contractual or employment action by the Health Maintenance Organization regarding the primary care physician shall not be based on the physician's participation in this procedure.

16. Rush Prudential's Certificate of Coverage, described in Paragraph 3 and attached as Exhibit A, is an ERISA governed employer sponsored welfare benefit plan.

17. Plaintiff filed a first Complaint in this action on January 23, 1998 in the Circuit Court of Cook County.

18. Defendant answered that first complaint on July 10, 1998.

19. Plaintiff moved for judgment on the pleadings in the first Complaint on August 14, 1998.

20. On November 2, 1998, the Circuit Court of Cook County entered a partial judgment on the pleadings for Plaintiff, ruling that the portion of the HMO Act which requires independent review is not preempted by ERISA and ordering Defendant to provide the independent review. A true and correct copy is attached as Exhibit H.

21. The independent review was done by Dr. A. Lee Dellon. Both parties agreed to Dr. Dellon as the independent review physician.

22. On December 15, 1998, Dr. Dellon submitted his independent review report, a true and correct copy of which is attached hereto as Exhibit G. The independent review report concludes that Plaintiff's surgery was medically necessary.

23. Once the non-preempted independent review was provided as required by Illinois law and as ordered by the Circuit Court of Cook County, Defendant Rush had no discretion to overrule the independent reviewer's determination of medical necessity.

24. Defendant Rush breached its obligation to Debra Moran under its ERISA-covered plan by one or more of the following acts or omissions:

(a) By failing and refusing to provide an independent review of the medical necessity of the proposed surgery as set forth in ¶13 above during December, 1997 and January, 1998;

(b) by refusing, despite Dr. Dellon's independent review in which he found the surgery medically necessary, to provide a proper utilization review, to abide by the Certificate and the Illinois HMO Act, and refusing to pay for the covered surgery;

(c) by refusing, despite the recommendation of Plaintiff's primary care physician that Defendant approve Plaintiff's surgery, to provide a proper utilization review, to abide by the Certificate and the Illinois HMO Act, and refusing to pay for the covered surgery;

(d) by refusing, despite the recommendation of the Medical Director of Centra, the joint venture contracting partner of Defendant which provides physician and hospital services for Defendant, to approve Plaintiff's surgery, to provide a proper utilization review, to abide by the Certificate and the Illinois HMO Act, and refusing to pay for the covered surgery.

25. Defendant Rush breached its obligation to pay under the Illinois HMO Act as part of the ERISA-covered plan by reason of one or more of the acts or omissions set forth in Paragraphs 24(a) through (d) above.

26. Defendant Rush breached the requirements of the Illinois HMO Act by reason of one or more of the Acts or omissions set forth in Paragraphs 24(a) through (d) above.

27. As a direct and proximate result of one or more of Defendant's breaches, as set forth in Paragraphs 24(a) through (d) above, Plaintiff was forced to:

(a) obtain the covered surgery and related medical treatment herself;

(b) take loans against the 401(k) retirement plans of her husband;

(c) take personal loans; and

(d) personally incur the expense of the requested surgery and follow-up care in the total amount of $94,841.27.

28. Defendant sought to remove this action from the Circuit Court of Cook County, *inter alia*, on the basis on that ERISA provides a remedy for any claimed violation of the Illinois HMO Act.

WHEREFORE, pursuant to 29 U.S.C. §1132(a)(1)(b) and (g), Debra Moran prays for a final judgment and order that Defendant Rush Prudential HMO, Inc.:

(a) reimburse Debra Moran in the amount of $94,841.27 for the expenses she incurred;

(b) pay Debra Moran prejudgment interest on the liquidated sum of $94,841.27;

(c) pay all expenses necessary to clear the personal loans and to clear the loans against the 401(k) retirement plans of Debra Moran's husband;

(d) pay Debra Moran's attorney's fees and costs incurred in bringing this action pursuant to 29 U.S.C. §1132(g);

(e) finding and declaring Rush Prudential had an obligation to provide an independent assessment of the

medical necessity of Debra Moran's proposed surgery because of the disagreement between the Plan Administrator and the primary care physician about the medical necessity of those proposed services, and finding and declaring that Rush Prudential had an obligation to provide independent review pursuant to the Illinois HMO Act;

(f) finding and declaring that Rush Prudential HMO had an obligation under the Illinois HMO Act to follow the conclusion of the independent reviewer about "medical necessity," and it had no discretion under that statute to contest the independent reviewer's conclusion concerning medical necessity; and

(g) for such other and further relief as the Court deems just in the circumstances.

ALTERNATIVE COUNT III -
ERISA - BREACH OF FIDUCIARY DUTY

Pursuant to 29 U.S.C. §1132(a)(1)(b) and (g), Plaintiff Debra Moran pleads alternatively as follows:

1. Defendant is an Illinois corporation doing business and maintaining an office in the County of Cook, State of Illinois.

2. Defendant is a health maintenance organization within the meaning and purview of the "Health Maintenance Organization Act," 215 ILCS §125/1/1 *et seq.*

3. Defendant issued, for and in consideration of monthly premiums, its certificate of group health coverage ("Certificate"), a copy of which is attached hereto and incorporated herein as Exhibit A.

4. Plaintiff, as spouse of subscriber Paul Moran, was and is at all times pertinent hereto, a qualified dependent under the terms of this Certificate and entitled to the benefits thereunder. Attached hereto and incorporated herein as Exhibit B is the Membership Card.

5. The provisions of the Illinois HMO Act, 215 ILCS §125/1-1 *et seq.*, including, §125/4-10, are a part of Defendant's Certificate as a matter of law. *Plumb* v. *Fluid Pump Service*, 124 F.3d 849, 859 (7th Cir. 1997).

6. Defendant also specifically adopted Illinois law as part of its Certificate by reason of the language of that Certificate at Page 34 of Exhibit A which provides:

> If the provisions of this Certificate do not conform to the requirements of any state or federal law that applies to this Certificate, the Certificate is automatically changed to conform with the requirements of that law.

7. Plaintiff was diagnosed with brachial plexopathy and thoracic outlet syndrome. On October 14, 1997, Dr. Arthur LaMarre, Plaintiff's primary care physician under the Certificate, recommended that she be approved to have surgery by Dr. Julia K. Terzis. A copy of said recommendation is attached hereto and incorporated herein as Exhibit C.

8. On October 23, 1997, the coverage for the requested surgery was denied "due to lack of medical necessity per plan certificate for the procedure requested." A true and correct copy of the denial is attached hereto and incorporated herein as Exhibit D.

9. Plaintiff appealed the denial of coverage and on November 11, 1997, Defendant affirmed its denial of coverage. A true and correct copy of the affirmance letter is attached hereto and incorporated as Exhibit E.

10. Plaintiff appealed the affirmance of denial of coverage to Defendant's Membership Advisory Committee. On December 4, 1997, said Committee met and shortly thereafter, issued its written decision again, affirming the denial of coverage. A true and correct copy of that written decision is attached hereto and incorporated herein as Exhibit F.

11. Plaintiff has exhausted her administrative remedies pursuant to the Certificate.

12. Plaintiff has repeatedly requested Defendant provide an independent review of the medical necessity of Plaintiff's surgery pursuant to the Certificate and the HMO Act, 215 ILCS §125/4-10.

13. In December, 1997 and January, 1998 Defendant refused to provide a proper utilization review of Plaintiff's surgery by an independent review of the medical necessity of Plaintiff's proposed surgery, or pursuant to the Certificate and the HMO Act, 215 ILCS §125/4-10, and Defendant has failed and refused to provide independent review or analysis, to comply with the Certificate or to comply with the statutory provision.

14. As a result, Debra Moran was forced to obtain the covered surgery and related medical treatment herself, at her own expense, during the period February 19, 1998 through August, 1998. She obtained the requested surgery and follow-up care herself from Dr. Julia K. Terzis and the surgery and follow-up care were successful.

15. The Illinois HMO Act, 215 ILCS §125/4-10 provides:

> §4-10(a) Medical Necessity - Dispute Resolution - Independent Second Opinion. Each Health Maintenance Organization shall provide a mechanism for the timely review by a physician holding the same class of license as the primary care physician, who is unaffiliated with the Health Maintenance Organization, jointly selected by the patient (or the patient's next of kin or legal representative if the patient is unable to act for himself), primary care physician and the Health Maintenance Organization in the event of a dispute between the primary care physician and the Health Maintenance Organization regarding the medical necessity of a covered service proposed by a primary care physician. In the event that the reviewing physician determines the covered service to be medically necessary, the Health Maintenance Organization shall

provide the covered service. Future contractual or employment action by the Health Maintenance Organization regarding the primary care physician shall not be based on the physician's participation in this procedure.

16. Rush Prudential's Certificate of Coverage, described in Paragraph 3 and attached as Exhibit A, is an ERISA governed employer sponsored welfare benefit plan.

17. Defendant Rush Prudential HMO had a fiduciary duty to Debra Moran, in its administration of the plan, to obtain an independent analysis of the medical necessity of Debra Moran's proposed surgery, once a dispute arose between the primary care physician and the plan as to such medical necessity. *Highshue* v. *AIG Life Ins. Co.*, 135 F.3d 1141 (7th Cir. 1998).

18. Rush Prudential breached its fiduciary duty to Debra Moran in one or more of the following respects:

(a) by failing and refusing to provide an independent review of the medical necessity of the proposed surgery as set forth in ¶13 above during December, 1997 and January, 1998;

(b) by refusing, despite Dr. Dellon's independent review, Exhibit G, which found the surgery medically necessary, to provide a proper utilization review, to abide by the Certificate and the Illinois HMO Act, and refusing to pay for the covered surgery;

(c) by refusing, despite the recommendation of Plaintiff's primary care physician that Defendant approve Plaintiff's surgery, to provide a proper utilization review, to abide by the Certificate and the Illinois HMO Act, and refusing to pay for the covered surgery;

(d) by refusing, despite the recommendation of the Medical Director of Centra, the joint venture contracting partner of Defendant which provides physician and hospital services for Defendant, to approve Plaintiff's surgery, to

provide a proper utilization review, to abide by the Certificate and the Illinois HMO Act, and refusing to pay for the covered surgery.

19. As a direct and proximate result of one or more of the acts or omissions set forth in Paragraph 18(a) through (d) above, Plaintiff was forced to:

(a) obtain the covered surgery and related medical treatment herself;

(b) take loans against the 401(k) retirement plans of her husband;

(c) take personal loans;

(d) personally incur the expense of the requested surgery and follow-up care in the total amount of $94,841.27.

WHEREFORE, Plaintiff Debra Moran prays, pursuant to 29 U.S.C. §1132(a)(1)(b), for a final judgment and order that Defendant Rush Prudential HMO, Inc.:

(a) reimburse Debra Moran in the amount of $94,841.27 for the expenses she incurred;

(b) pay Debra Moran prejudgment interest on the liquidated sum of $94,841.27;

(c) pay all expenses necessary to clear the personal loans and to clear the loans against the 401(k) retirement plans of Debra Moran's husband;

(d) pay Debra Moran's attorney's fees and costs incurred in bringing this action pursuant to 29 U.S.C. §1132(g);

(e) finding and declaring Rush Prudential had an obligation to provide an independent assessment of the medical necessity of Debra Moran's proposed surgery because of the disagreement between the Plan Administrator and the primary care physician about the medical necessity of those proposed services, and finding and declaring that Rush

Prudential had an obligation to provide independent review pursuant to the Illinois HMO Act;

(f) finding and declaring that Rush Prudential HMO had an obligation under the Illinois HMO Act to follow the conclusion of the independent reviewer about "medical necessity," and it had no discretion under that statute to contest the independent reviewer's conclusion concerning medical necessity; and

(g) for such other and further relief as the Court deems just in the circumstances.

By: /s/ Daniel P. Albers
One of the Attorneys on
Behalf of Plaintiff
Debra C. Moran

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Dated: April 5, 1999

September 10, 2001

(1)

Supreme Court, U.S.
FILED
SEP 10 2001
CLERK

No. 00-1021

IN THE

Supreme Court of the United States

RUSH PRUDENTIAL HMO, INC.,
Petitioner,

v.

DEBRA C. MORAN AND STATE OF ILLINOIS,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

BRIEF FOR PETITIONER

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56 pp

QUESTION PRESENTED

Section 4-10 of the Illinois Health Maintenance Organization Act provides that, if a patient's primary care physician deems a proposed procedure desired by the patient to be medically necessary, but the HMO disagrees and denies coverage for the procedure, the patient may have the HMO's decision reviewed by an outside physician, and the HMO must abide by the reviewing physician's determination. The Seventh Circuit held in this case that this independent review process was not preempted by the Employee Retirement Income Security Act ("ERISA")—in square conflict with a recent Fifth Circuit decision holding that a materially identical Texas law *was* preempted by ERISA.

The question presented is:

Whether the independent review provision of the Illinois HMO Act, which is similar to laws adopted in 37 States and the District of Columbia, is preempted by ERISA.

PARTIES TO THE PROCEEDING AND RULE 29.6 STATEMENT

Petitioner Rush Prudential HMO, Inc., now known as UNICARE Health Plans of the Midwest, Inc., is wholly owned by UNICARE Illinois Services, Inc., an Illinois corporation, which is ultimately owned by WellPoint Health Networks Inc., a publicly held company.

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IN THE

Supreme Court of the United States

No. 00-1021

RUSH PRUDENTIAL HMO, INC.,
Petitioner,

v.

DEBRA C. MORAN AND STATE OF ILLINOIS,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

BRIEF FOR PETITIONER

OPINIONS BELOW

The opinion of the Seventh Circuit, together with the dissent from denial of rehearing en banc, is reported at 230 F.3d 959. The opinion is reproduced in the appendix to the petition for certiorari ("Pet. App.") at 1a, and the dissent from denial of rehearing en banc is reproduced at Pet. App. 24a. The opinions and orders of the United States District Court for the Northern District of Illinois dated June 9, 1998, March 24, 1999, May 6, 1999, and June 15, 1999, are not reported; they are reproduced at Pet. App. 28a, 35a, 44a, and 47a, respectively.

JURISDICTION

The judgment of the Seventh Circuit was entered on October 19, 2000. Pet. App. 1a. The petition for certiorari was filed on December 22, 2000, and granted on June 29, 2001. 121 S. Ct. 2589. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The Supremacy Clause of the United States Constitution provides in pertinent part:

> This Constitution, and the Laws of the United States which shall be made in Pursuance thereof * * * shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding. [U.S. Const., art. VI, cl. 2.]

Section 502(a) of the Employee Retirement Income Security Act of 1974 ("ERISA")—the statute's civil enforcement provision—provides in pertinent part:

> (a) Persons empowered to bring a civil action. A civil action may be brought—(1) by a participant or beneficiary—(A) for the relief provided for in subsection (c) of this section, or (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan * * *. [29 U.S.C. § 1132(a).]

Section 514(a) of ERISA—the preemption provision—provides in pertinent part:

> (a) Supersedure; effective date. Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. [29 U.S.C. § 1144(a).]

Section 514(b)(2) of ERISA—the saving clause—provides in pertinent part:

> (b) Construction and application. * * * (2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.
>
> (B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title * * * , nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies. [29 U.S.C. § 1144(b)(2).]

Section 4-10 of the Illinois Health Maintenance Organization Act provides:

> Medical Necessity—Dispute Resolution—Independent Second Opinion. Each Health Maintenance Organization shall provide a mechanism for the timely review by a physician holding the same class of license as the primary care physician, who is unaffiliated with the Health Maintenance Organization, jointly selected by the patient (or the patient's next of kin or legal representative if the patient is unable to act for himself), primary care physician and the Health Maintenance Organization in the event of a dispute between the primary care physician and the Health Maintenance Organization regarding the medical necessity of a covered service proposed by a primary care physician. In the event that the reviewing physician determines the covered service to be medically

necessary, the Health Maintenance Organization shall provide the covered service. Future contractual or employment action by the Health Maintenance Organization regarding the primary care physician shall not be based solely on the physician's participation in this procedure. [215 Ill. Comp. Stat. 125/4-10.]

INTRODUCTION

Health Maintenance Organizations, or HMOs, have become a common feature of the American health care system. Their growing prominence has drawn the attention of state lawmakers, who in recent years have subjected HMOs to increasing regulation. States have demonstrated particular interest in regulating "utilization review," the process by which HMOs determine whether patient treatments are covered under the terms of the HMO contract, a determination which is typically "keyed to standards of medical necessity or the reasonableness of the proposed treatment." *Pegram* v. *Herdrich*, 530 U.S. 211, 219 (2000).

Petitioner Rush Prudential HMO, Inc. ("Rush") is an HMO that provided access to medical and hospital care under a medical benefits plan sponsored by the employer of the husband of respondent Debra C. Moran ("Moran"). The plan is an employee welfare benefit plan subject to the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.* Under the applicable Certificate of Group Coverage ("Certificate"), Rush provides coverage only when it determines services to be "medically necessary," and it exercises "the broadest possible discretion" to make that determination. Pet. App. 3a (quoting Certificate).

Moran sought to have Rush pay for an unusual surgical procedure that Rush had determined was not medically necessary. Moran disagreed with that determination. ERISA provided Moran with a remedy in such a circumstance—a civil action "to recover benefits due to [her] under the terms of [her] plan," or "to enforce [her] rights under the terms of

the plan." 29 U.S.C. § 1132(a)(1)(B). As this Court held in *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 52 (1987), this remedy "was intended to be exclusive." Moran, however, invoked a different remedy to recover the benefits to which she believed she was entitled, a remedy provided by the Illinois Health Maintenance Organization Act, 215 Ill. Comp. Stat. 125/4-10: independent review of Rush's medical necessity determination by an unaffiliated physician. Under the Illinois law, if that physician "determines the covered service to be medically necessary, the [HMO] shall provide the covered service." *Id.* The reviewing physician made such a determination in this case, and Moran brought a claim under Section 4-10 to recover the benefits the reviewer had decreed should be paid. Rush resisted, on the ground that the state law independent review remedy was preempted by ERISA.

That was what the Fifth Circuit determined with respect to an indistinguishable Texas independent review law, holding that the law "creates an alternative mechanism through which plan members may seek benefits due them under the terms of the plan," in "conflict with ERISA's exclusive remedy." *Corporate Health Ins., Inc.* v. *Texas Dep't of Ins.*, 215 F.3d 526, 539 (5th Cir.), *further opinion on pet. for reh'g*, 220 F.3d 641 (2000), *pet. for cert. filed sub nom. Montemayor* v. *Corporate Health Ins., Inc.*, No. 00-665 (Oct. 24, 2000). The Seventh Circuit below disagreed, reasoning that the Illinois law "simply adds to the contract, by operation of law, an additional dispute resolving mechanism," which can then be enforced like any other term of the contract in the civil action authorized by ERISA. Pet. App. 22a. Judge Posner, joined by three other judges, dissented from the denial of rehearing en banc. He explained that the Illinois law "establishes a system of appellate review of benefits decisions that is distinct from the provision in ERISA for suits in federal court to enforce entitlements conferred by ERISA plans. By doing

so, the law interferes with the federally specified system for enforcing such entitlements." *Id.* at 25a-26a.

The decision below is wrong and should be reversed. The Illinois law rather plainly affords a new and different remedy to those seeking benefits under an ERISA plan, and this Court has squarely held in a unanimous opinion that Congress intended the remedies provided under ERISA to be exclusive. Calling the new state law remedy a plan term added "by operation of law," and then reasoning that the action to implement that remedy simply seeks to enforce a plan term as authorized by ERISA, Pet. App. 22a, would render this Court's ERISA preemption jurisprudence a dead letter, and "invite[] states to evade the preemptive force of ERISA simply by deeming [their] regulations of ERISA plans to be plan terms." *Id.* at 27a (Posner, J., dissenting from denial of rehearing en banc). Such a result would be flatly inconsistent with this Court's bedrock recognition that Congress intended ERISA's remedies to be exclusive.

STATEMENT OF THE CASE

Statutory Background. 1. ERISA "subjects to federal regulation plans providing employees with fringe benefits." *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983). ERISA's "intricate, comprehensive" statutory scheme, *Boggs* v. *Boggs*, 520 U.S. 833, 841 (1997), regulates employee pension and welfare plans providing "medical, surgical or hospital care or benefits" "through the purchase of insurance or otherwise." 29 U.S.C. § 1002(1), (3).

One of ERISA's "principal goals," *Egelhoff* v. *Egelhoff*, 121 S. Ct. 1322, 1328 (2001), was to "establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits." *Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. 1, 9 (1987). When it passed ERISA, Congress intended

> to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government * * * [and to prevent] the potential for conflict in substantive law * * * requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction. [*New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645, 656-657 (1995).]

Several provisions safeguard the uniformity of ERISA's comprehensive administrative scheme. Section 514(a) preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA. 29 U.S.C. § 1144(a). ERISA contains a few exceptions to that broad preemption provision, only one of which is potentially relevant here: Section 514(b)(2)(A), the saving clause, which exempts from preemption "any law of any State which regulates insurance, banking, or securities." *Id.* § 1144(b)(2)(A).

ERISA also contains a civil enforcement provision, Section 502(a), *id.* § 1132(a), which this Court has found to be the "exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits." *Pilot Life*, 481 U.S. at 52. The civil enforcement provision—"one of the essential tools for accomplishing the stated purposes of ERISA," *id.*—allows plan participants, among other things, to sue to recover benefits due under the plan, to enforce their rights under the plan, or to clarify their rights to future benefits under the plan. 29 U.S.C. § 1132(a)(1)(B). As this Court held in *Pilot Life*, the provisions of Section 502(a), crafted by Congress with "deliberate care,"

> set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit

> plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA. [481 U.S. at 54.]

See also Massachusetts Mut. Life Ins. Co. v. *Russell*, 473 U.S. 134, 146 (1985) ("The six carefully integrated civil enforcement provisions found in § 502(a) * * * provide strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly") (emphasis in original).

2. Despite the foregoing, recent years have seen a proliferation of state laws entitling a patient to an independent review or external appeal of an HMO's decision that a particular procedure is not covered by an ERISA plan. By 2000, thirty-seven States and the District of Columbia had enacted independent review laws. *See* Pet. for Cert. at 16-17. The laws vary in their scope and in the form of review they require. Some States require HMOs to submit challenged benefits determinations to panels of reviewers composed of from one to seven people and varyingly made up of health care practitioners, fellow employees, attorneys, or some combination of these. *See, e.g.*, G. Dallek & K. Pollitz, Georgetown Univ. Inst. for Health Care Research & Policy, *External Review of Health Plan Decisions: An Update* 9 & n.10, 13 (May 2000) (noting, among others, Michigan's "seven-member task force," which independently reviews non-expedited benefits determinations). Other States provide for review by "Independent Review Organizations," or "IROs," which in turn contract with physicians who, singly or in groups (again depending on the state law) perform independent reviews. *Id.* at 9. Independent review laws also vary in their scope: some States limit independent or external review to an HMO's determination that a proposed procedure is not medically necessary or appropriate, while

others permit review of a broader range of decisions, including basic coverage determinations. *Id.* at 6-7, 13.

As Judge Posner observed below, independent external review laws "add[ ] heavy new procedural burdens to ERISA plans." Pet. App. 26a (dissent from denial of rehearing en banc). Indeed, "[t]he expense of an arbitration by the independent physician could easily equal the expense of the medical treatment that the HMO had refused to authorize." *Id.*

Facts. Moran sought treatment in 1996 from Dr. Arthur LaMarre, a Rush-affiliated primary care physician, for pain, numbness, loss of function, and decreased mobility in her right shoulder. LaMarre began to treat Moran's symptoms with physiotherapy. While she was still undergoing this treatment, Moran sought the opinion of Dr. Julia Terzis, an out-of-network surgeon in Virginia. Terzis confirmed the diagnosis of Moran's symptoms as brachial plexopathy and thoracic outlet syndrome ("TOS"), a syndrome caused by the compression of nerves between the shoulder and neck. *See* Pet. App. 3a-4a.

As treatment for Moran's condition, "surgery is not indicated unless more conservative measures"—such as the physiotherapy LaMarre had already prescribed—"fail to manage the symptoms." *Id.* at 4a. If surgery becomes necessary, "the standard procedure for TOS involves decompression by way of first rib resection (the complete removal of the uppermost rib) or first rib resection with scalenectomy (the removal of the rib and the attached muscle)." *Id.* Terzis, however, recommended for Moran a more complicated and rare surgical procedure that Terzis herself had developed: "Dr. Terzis' surgery consists of rib resection, extensive scalenectomy, and, if indicated, microneurolysis of the lower roots of the brachial plexus under intraoperative microscopic magnification." *Id.*

Moran asked LaMarre to obtain approval from Rush for the Terzis surgery. LaMarre sought out the views of two other thoracic surgeons, neither of whom recommended the Terzis surgery for Moran, but LaMarre nonetheless requested that Rush approve the surgery. After Rush declined to approve payment for the treatment because it was not medically necessary, Moran appealed the decision pursuant to the review procedure provided under the benefit plan. Upon further review, Rush affirmed its denial on the ground that the extensive surgery proposed by Terzis was not medically necessary, but advised Moran that it would cover the standard TOS surgery—first rib resection with scalenectomy—performed by a network surgeon. Moran made an additional appeal to Rush's membership advisory committee, which upheld Rush's medical necessity decision. *Id.* at 5a.

Having exhausted the various review procedures provided in the benefit plan without obtaining a favorable ruling on medical necessity, Moran could have pursued the remedy afforded by ERISA—a civil action to recover benefits due or to enforce her asserted rights under the plan. 29 U.S.C. § 1132(a)(1)(B). In such an action, Rush's determination pursuant to plan procedures that the Terzis surgery was not medically necessary could be set aside only if the court—applying standards developed under ERISA's body of federal common law—determined that it constituted an abuse of discretion. *See, e.g.*, Pet. App. 54a-55a (citing cases).

Moran, however, elected a different remedy: a binding determination of her claim for benefits by a different decisionmaker, as mandated by Section 4-10 of the Illinois HMO Act. Under Section 4-10, a determination by an HMO that a procedure is not medically necessary may be reviewed by an independent physician. 215 Ill. Comp. Stat. 125/4-10. The law provides that if the reviewing physician "determines the covered service to be medically necessary, the [HMO] shall provide the covered service." *Id.*

While Moran's request for independent review was still pending, she decided to undergo the microneurolysis surgery. Dr. Terzis performed the 14-hour procedure, which together with post-operative care cost nearly $95,000. After paying for the surgery herself, Moran sought reimbursement from Rush. Rush undertook yet another investigation of the claim, seeking opinions from additional experts. None of the doctors consulted by Rush concluded that Moran's surgery was medically necessary, and Rush declined to reimburse Moran. Pet. App. 6a.

Proceedings Below. This litigation began when Moran filed a complaint in state court seeking, *inter alia*, specific performance of the external review provisions in Section 4-10 of the Illinois law. J.A. 12.[1] The state court ordered Rush to permit the review provided for in Section 4-10. J.A. 15-16. That review was conducted by one Dr. Dellon, who "concluded that the surgery was medically necessary," while noting that he would have used a less intrusive and less time-consuming procedure. Pet. App. 8a. After reviewing Dr. Dellon's report and reports from three other physicians reaching the opposite conclusion, Rush again denied Moran's claim on the ground that the surgery was not medically necessary.

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[1] Because the complaint sought to obtain or compel benefits under an ERISA-regulated employee welfare benefit plan and was, in Rush's view, completely preempted by federal law, Rush removed the case to federal court. Moran moved to remand to state court, and the District Court granted her motion. The court reasoned that the request for specific performance of the review procedure was not a claim under ERISA's civil enforcement provisions and therefore was not completely preempted. The District Court noted, however, that a claim for reimbursement after the external review had been completed might well be a claim for benefits that is completely preempted by ERISA. *See* Pet. App. 28a, 33a-34a.

Moran amended her complaint to seek reimbursement for the surgery in the amount of $94,841.27. J.A. 17, 21. Rush removed the suit to federal court on the ground that a demand for reimbursement is completely preempted by ERISA and must be brought under Section 502(a) of ERISA, the statute's civil enforcement provision. 29 U.S.C. § 1132(a). Recognizing that the claim was now simply one for benefits, and that ERISA provided the exclusive vehicle for securing benefits under a covered plan, the District Court denied Moran's motion to remand. Pet. App. 41a-43a.

The District Court determined that Moran's Section 4-10 demand for payment was "preempted by ERISA's civil enforcement policy in § 502(a)." *Id.* at 53a. As the court explained:

> Regardless of how she characterizes it, Moran's current claim is a § 502(a) denial of benefits claim. Moran asserts her right to have Rush cover the costs of medical treatment pursued outside of her HMO plan. Rush refused to reimburse her for the treatment. Rush's refusal is a determination of benefits within the meaning of ERISA. Accordingly, Moran's claim for reimbursement is preempted by ERISA. [*Id.* at 41a-42a.]

The District Court also rejected Moran's effort to escape preemption through ERISA's so-called "saving clause," 29 U.S.C. § 1144(b)(2)(A). That clause provides that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." Finding that the Illinois law "does not operate to transfer or spread a policyholder's risk" but only "affects the administration and adjudication structure of a health plan in particular instances," the District Court concluded that Section 4-10 is not a law that "regulates

insurance" and that the saving clause therefore did not rescue the state law from preemption. Pet. App. 42a-43a.[2]

After concluding that Moran's claim for reimbursement was properly characterized as a claim for benefits under the ERISA plan, and was therefore properly removed to federal court, the District Court analyzed Moran's demand for reimbursement under principles of federal law. Given that Moran's ERISA plan "afforded Rush 'the broadest possible discretion to interpret the terms of the * * * Certificate and to determine which benefits the Employee and his/her eligible dependents are entitled to receive,' " *id.* at 56a (quoting Certificate), those principles required review of Rush's determination under "a highly deferential standard." *Id.* at 54a. Applying that standard, the District Court entered summary judgment for Rush on the ground that "Rush did not abuse its discretion or act arbitrarily in denying Moran's benefits claim." *Id.* at 56a. As the District Court concluded, "[i]n reaching its [benefits] determination, Rush acted in accordance with the protocol set out in Moran's insurance certificate." *Id.* In addition, Rush relied on expert opinions

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[2] Moran sought reconsideration of the District Court's decision on the saving clause after this Court's decision in *UNUM Life Insurance Co. of America* v. *Ward*, 526 U.S. 358 (1999), which clarified the test to be applied for determining when a law "regulates insurance." The District Court determined that even if the saving clause applied, an exemption from the clause—the so-called "deemer clause"—once again gave preemptive effect to the federal law. Pet. App. 46a. The deemer clause provides that an employee benefit plan cannot "be deemed to be an insurance company or other insurer, * * * or to be engaged in the business of insurance" for purposes of applying the saving clause. 29 U.S.C. § 1144(b)(2)(B). As the District Court explained, "[b]ecause the Illinois HMO Act has the effect of directly regulating employee benefit plans rather than an insurance company, it is exempt from the savings clause under the deemer clause." Pet. App. 46a.

establishing that "Moran's condition did not require extensive brachial plexopathy treatment." *Id.* at 57a-58a.

The Seventh Circuit reversed. It first determined that removal was proper because "Ms. Moran's state law claims are properly recharacterized as claims for benefits under Section 502(a)(1)(B) of ERISA and, therefore, are completely preempted." Pet. App. 13a. The Court of Appeals also concluded that the state law claims were initially within the reach of ERISA's express preemption provision, found in Section 514(a) of the Act. 29 U.S.C. § 1144(a) (except as provided in subparagraph (b), the provisions of ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan"). *See* Pet. App. 14a.

The Seventh Circuit then considered whether Section 4-10 of the Illinois law regulates insurance and therefore could escape preemption under the saving clause. Applying this Court's multi-factor test for determining whether a law regulates insurance, *see UNUM*, 526 U.S. at 367, the Seventh Circuit concluded that Section 4-10 did so. Pet. App. 17a.[3]

The Seventh Circuit then considered whether Section 4-10, despite falling within the saving clause, was nonetheless preempted because it "conflicts with a substantive provision of ERISA." *Id.* at 19a. Despite having concluded when considering the propriety of removal that "Moran's state law claims are properly recharacterized as claims for benefits under § 502(a)(1)(B) of ERISA and, therefore, are completely preempted," Pet. App. 13a, the court now found that

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[3] The court also determined that the "deemer clause" did not apply in this case. The employee welfare benefit plan here is not self-funded but rather is an insured plan, and the Court of Appeals determined that the deemer clause did not apply to such plans. *Id.* at 18a-19a.

the provisions of Section 4-10 were *not* preempted by Section 502(a)(1)(B). Pet. App. 19a-23a. It reasoned that the provisions of Section 4-10 were incorporated into the plan and that therefore "a suit by [Moran] to enforce the HMO Act's provisions is simply a suit to enforce the terms of the plan—precisely the sort of suit that is contemplated by § 502(a)(1)(B) 'to enforce rights' and 'to recover benefits' under the plan." Pet. App. 21a.

The court recognized that its decision conflicted with the Fifth Circuit's decision in *Corporate Health*, "in which the court considered an independent review statute from Texas that is quite similar to § 4-10 of Illinois' HMO Act." Pet. App. 19a. The Seventh Circuit disagreed with the Fifth Circuit's conclusion that the state law independent review mechanism created an alternative civil enforcement scheme inconsistent with that provided in ERISA itself. It relied instead on its view that Section 4-10 created an additional term of the plan by operation of law. Thus, it concluded that a suit to enforce rights under the provision "is simply a suit to enforce the terms of the plan," and not an enforcement mechanism in conflict with the exclusive mechanism provided by ERISA. *Id.* at 21a. Applying Section 4-10, the Court of Appeals reversed the District Court's summary judgment in favor of Rush and granted summary judgment to Moran, enforcing the independent reviewer's determination under Section 4-10 that the Terzis surgery was "medically necessary." *Id.* at 24a.

Four circuit judges voted to rehear the case en banc. Writing for those judges in a dissent from the denial of rehearing en banc, Judge Posner observed that the "panel's decision creates a square conflict with another circuit, is probably unsound, and will affect an enormous number of cases." *Id.* In the view of the dissenters, "[t]he Illinois statute, unless preempted by ERISA insofar as the statute's application to ERISA plans is concerned, will * * * effect a substantial change in the employer's plan." *Id.* at 25a. The state law

"establishes a system of appellate review of benefits decisions that is distinct from the provision in ERISA for suits in federal court to enforce entitlements conferred by ERISA plans," and therefore "interferes with the federally specified system for enforcing such entitlements." *Id.* at 25a-26a. The dissenters observed that the panel's reliance on the fiction that state law is incorporated into the plan would permit "transparent * * * evasion[s] of ERISA's preemption clause." *Id.* at 26a-27a.

Finally, the dissenters noted the "unresolved tension in the panel's opinion" between two propositions on which it relied: "first, that the Illinois law regulates insurance rather than ERISA plans and thus is not preempted; second, that by virtue of Illinois law the requirement of independent physician review is written not only into an insurance contract but also into the plan itself, which makes the requirement enforceable in federal court." *Id.* at 27a. Judge Posner explained that "[t]he two propositions are incompatible." *Id.*

> If the statute merely regulates insurance and therefore is not preempted, how can it be part of an ERISA plan and enforceable in federal court? If, on the other hand, the requirement imposed by the statute is and must be incorporated into the plan, then Illinois has done more than merely regulate the contents of an insurance policy. It has regulated the contents of an ERISA plan—which means that its law is preempted. [*Id.*]

This Court granted certiorari. 121 S. Ct. 2589 (2001).

SUMMARY OF ARGUMENT

I. ERISA provides a remedy for beneficiaries under an employee pension or welfare plan who believe they have been wrongfully denied benefits under the plan. Section 502(a) specifies that beneficiaries may bring a civil action "to recover benefits due * * * under the terms of [the] plan" or "to enforce [their] rights under the terms of the plan." 29

U.S.C. § 1132(a)(1)(B). This Court held in *Pilot Life* that this remedy was intended to be "the *exclusive vehicle* for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits." 481 U.S. at 52 (emphasis added). As the Court explained, this conclusion was compelled by Congress' clear intent that the question of "rights and obligations" under an ERISA plan be governed by a developing body of uniform federal common law, not disparate state laws. *Id.* "The expectations that a federal common law of rights and obligations under ERISA-regulated plans would develop * * * would make little sense if the remedies available to ERISA participants and beneficiaries under 502(a) could be supplemented by varying state laws." *Id.* at 56.

Section 4-10 of the Illinois HMO Act, however, purports to afford beneficiaries an additional and alternative remedy "to recover benefits due" or "to enforce [their] rights under the terms of the plan." Under Section 4-10, a beneficiary can force the HMO to submit the question of medical necessity under a plan to an unaffiliated physician for a de novo determination that binds the HMO. This compulsory arbitration offers beneficiaries a more attractive remedy than that afforded by ERISA, because as a matter of federal common law an HMO's discretionary medical necessity determination is reviewed in a Section 502(a) action only for abuse of that discretion. *See Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101, 111 (1989). The additional and alternative remedy provided by Section 4-10 necessarily conflicts with ERISA's exclusive remedy, and is preempted.

The court below erred in ruling that there was no conflict because Section 4-10 was "incorporated" into the ERISA plan, and then enforced in what the court recharacterized as a Section 502(a) suit. Under such circular reasoning, any State could impose any type of remedy, simply by deeming it a term of an ERISA plan. This Court's considered conclusion

that Congress intended ERISA's remedial scheme to be exclusive is not so easily circumvented.

II. Nor is Section 4-10 saved from preemption by ERISA's saving clause. Although it is often difficult to determine whether a state law falls under the imprecise terms of that clause, *Pilot Life* held that a state law that conflicted with ERISA's exclusive remedial scheme could not be considered to be within the scope of the clause. Whatever laws the saving clause was meant to save from preemption, additional and alternative state law remedies were not among them, and Section 4-10 accordingly cannot escape preemption.

The same result follows from application of the "tests" for whether a state law "regulates insurance" under the saving clause. Section 4-10 is not a regulation of insurance as a matter of common sense because it is directed at HMOs, not insurers, and the two are not the same—not all HMOs offer insurance or bear insurance risk. The McCarran-Ferguson factors also confirm that Section 4-10 does not regulate the business of insurance. First, Section 4-10 does not transfer or spread risk, but simply affords an additional means of enforcing the risk-spreading previously agreed to in the plan. Second, the provision is not an integral part of an insurance policy relationship, because the terms of that relationship were set in the plan. Section 4-10 simply provides an alternative method of enforcing that relationship. Third, Section 4-10 is not limited to entities in the insurance industry, but applies to HMOs regardless of whether they act as insurers or third-party administrators. For all these reasons—but "most importantly, the clear expression of congressional intent that ERISA's civil enforcement scheme be exclusive," *Pilot Life*, 481 U.S. at 57—Section 4-10 is preempted and not saved by the saving clause.

ARGUMENT

I. THE INDEPENDENT REVIEW PROVISION OF THE ILLINOIS HMO ACT CONFLICTS WITH ERISA'S EXCLUSIVE REMEDIAL SCHEME

This Court, and the lower courts, have often struggled with the scope of ERISA preemption. *See De Buono* v. *NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 808 n.1 (1997) (noting 16 ERISA preemption cases between 1974 and the 1996 Term). But there is one area of ERISA where the Court has had no difficulty discerning a bright line preemption rule. The Court has consistently and repeatedly held that state laws that seek to supplant or add to the exclusive remedies set forth in Section 502(a) of ERISA, 29 U.S.C. § 1132(a), are necessarily preempted because such laws conflict with Congress' overriding intent to create a uniform national system, governed by federal statutory and common law, for enforcing rights under ERISA plans. *See, e.g.*, *Ingersoll-Rand Co.* v. *McClendon*, 498 U.S. 133, 142-145 (1990); *Metropolitan Life Ins. Co.* v. *Taylor*, 481 U.S. 58, 65 (1987); *Pilot Life*, 481 U.S. at 52-54.

Section 4-10 is preempted under these precedents because it provides an additional, and alternative, remedy for those seeking benefits under an ERISA plan, and therefore conflicts with ERISA's exclusive remedial scheme. The attempted reconciliation offered by the court below—that Section 4-10 poses no conflict with ERISA's exclusive remedies because it merely adds a mandatory term to the plan, which can then be enforced through ERISA—is no reconciliation at all and, if adopted by this Court, would nullify Congress' intent to establish a uniform federal scheme for enforcing rights under ERISA plans.

A. Section 4-10 Conflicts With ERISA's Exclusive Remedy For The Recovery Of Benefits Under An ERISA Plan And Is Therefore Preempted

"One of the principal goals of ERISA is to enable employers 'to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits.' " *Egelhoff*, 121 S. Ct. at 1328 (quoting *Fort Halifax*, 482 U.S. at 9). That goal is accomplished in large part through ERISA's exclusive remedies, set forth in Section 502(a) of the Act. In Section 502(a), Congress enacted "a 'carefully integrated' civil enforcement scheme that 'is one of the essential tools for accomplishing the stated purposes of ERISA.' " *Ingersoll-Rand*, 498 U.S. at 137 (quoting *Pilot Life*, 481 U.S. at 52, 54) (additional quotation and citation omitted). Among other things, Section 502(a) provides an exclusive federal remedy for a beneficiary seeking "to recover benefits due to him under the terms of his plan" or "to enforce his rights under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B).

The exclusivity of the Section 502(a) remedies is well-established. As this Court has held,

> Congress clearly expressed an intent that the civil enforcement provisions of ERISA § 502(a) be the *exclusive* vehicle for actions for ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits, *and that varying state causes of action for claims within the scope of § 502(a) would pose an obstacle to the purposes and objectives of Congress.* [*Pilot Life*, 481 U.S. at 52 (emphases added).[4]]

[4] *See also id.* at 54 ("The deliberate care with which ERISA's civil enforcement remedies were drafted and the balancing of policies embodied in its choice of remedies argue strongly for the conclusion that ERISA's civil enforcement remedies were intended to be exclusive.").

The exclusive remedies of Section 502(a) have a broader preemptive effect than do other provisions of federal law. ERISA's exclusive remedies have "extraordinary pre-emptive power," such as has been found in only one other federal statute, Section 301 of the Labor Management Relations Act, 29 U.S.C. § 185. *Taylor*, 481 U.S. at 65. Congress not only intended to preempt state laws that conflict with ERISA's exclusive remedies, but also expressed a "clear intention to make § 502(a)(1)(B) suits brought by participants or beneficiaries federal questions for purposes of federal court jurisdiction * * *." *Id.* at 66. All actions asserting improper processing of benefits under an ERISA plan are accordingly "treated as federal questions" arising from a "federal common law of rights and obligations under ERISA-regulated plans." *Pilot Life*, 481 U.S. at 56. *See id.* (" 'It is also intended that a body of Federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans.' ") (quoting 120 Cong. Rec. 29942 (1974) (Sen. Javits)); *accord Firestone*, 489 U.S. at 110. Any suit attempting to set forth a state law cause of action seeking to recover benefits under an ERISA plan is preempted, and becomes " 'purely a creature of federal law notwithstanding the fact that state law would provide a cause of action in the absence of [federal law].' " *Taylor*, 481 U.S. at 64 (quoting *Franchise Tax Bd.* v. *Construction Laborers Vacation Trust*, 463 U.S. 1, 23 (1983)).

Section 4-10 attempts to supplant ERISA's exclusive federal remedies, and is therefore preempted. The sole effect of Section 4-10 is to provide an alternative state law remedy in place of the exclusive remedy under ERISA "to recover benefits due * * * under the terms of his plan" or "to enforce * * * rights under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). Moran seeks nothing other than benefits that she believes are "medically necessary" and, therefore, covered under the terms of the plan as written. *See* Opp.

Cert. 7 ("Moran sought * * * to recover benefits under and to enforce her rights under the terms of her plan"). Yet instead of utilizing the exclusive remedy authorized under ERISA for recovery of those benefits, Moran invoked the remedy under Section 4-10, which requires that her claim for benefits under the plan be determined by a different decisionmaker.

Under Section 502(a)(1)(B) and its implementing federal common law, ERISA's exclusive remedy consists of an action under federal law to determine whether Rush acted arbitrarily or capriciously in exercising the full discretion conferred on it to interpret the terms of the plan, including the term "medically necessary." *See Firestone*, 489 U.S. at 110-112; Pet. App. 54a-55a (citing cases). By contrast, the alternative remedy invoked by Moran under Section 4-10 consists of a form of binding de novo arbitration before an independent physician. Under Section 4-10, "[i]n the event that the reviewing physician determines the covered service to be medically necessary, the Health Maintenance Organization shall provide the covered service." Section 4-10 does not provide employees with any additional benefits under the plan; it simply purports to give them a different way to recover plan benefits, by appealing to a different decisionmaker.[5]

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[5] The conflict with ERISA's exclusive remedies is underscored by the fact that Section 4-10 also conflicts with ERISA's fiduciary requirements. Under ERISA, plan administrators must provide for a full and fair review of benefits denials "by the appropriate named fiduciary." 29 U.S.C. § 1133(2). The independent reviewer under Section 4-10, who is expressly required to be "unaffiliated with the Health Maintenance Organization," is not a fiduciary of the plan as required by this provision. Nor is the reviewer someone whom the plan administrator, independently exercising its own fiduciary duties, has designated to carry out fiduciary responsibilities under the plan. *See id.* § 1105(c)(1)(b). Rather, the reviewer is an *independent*, external decisionmaker who is mandated by state law to resolve certain disputes between the plan's fiduciary and its

As the District Court succinctly put it:

> Regardless of how she characterizes it, Moran's current claim is a § 502(a) denial of benefits claim. Moran asserts her right to have Rush cover the costs of medical treatment pursued outside of her HMO plan. Rush refused to reimburse her for the treatment. Rush's refusal is a determination of benefits within the meaning of ERISA. Accordingly, Moran's claim for reimbursement is preempted by ERISA. [Pet. App. 41a-42a (citations omitted).]

This Court's precedents establish that such an alternative state law remedy impermissibly conflicts with ERISA's exclusive remedies and the federal common law governing ERISA claims. For example, in *Pilot Life*, the Court considered a state law claim for, among other things, "damages for failure to provide benefits under [an] insurance policy." 481 U.S. at 43. The Court held that this claim, and the others asserted in that case, conflicted with ERISA's exclusive remedies. As the Court explained,

> the detailed provisions of § 502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of certain others under the federal scheme would be completely undermined if ERISA plan participants and beneficiaries were free to obtain remedies un-

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beneficiaries through a de novo determination of medical necessity. Under ERISA, an HMO fiduciary's discretionary determination of medical necessity is reviewed by federal judges, who apply a uniform body of federal common law to determine whether the plan fiduciary has abused the discretion granted to it under the plan.

der state law that Congress rejected in ERISA. [*Id.* at 54.]

See also Travelers, 514 U.S. at 646 (ERISA preempts laws that provide "alternative enforcement mechanisms"); *Taylor*, 481 U.S. at 66 (holding that state law claims for benefits owed under ERISA plan were "displaced by the civil enforcement provisions of § 502(a)").

Likewise, in *Ingersoll-Rand*, *supra*, the Court considered a claim under Texas law seeking damages for a wrongful discharge allegedly motivated by a desire to prevent the plaintiff from accruing vested rights under an ERISA pension plan. Following *Pilot Life*, the Court held that this claim was preempted because it conflicted with ERISA's exclusive remedy intended to accomplish the same objective. *See* 498 U.S. at 142 ("Even if there were no express pre-emption * * *, the Texas cause of action would be pre-empted because it conflicts directly with an ERISA cause of action."). In that case, the exclusive remedy was an action under Section 502(a)(3) to enforce the wrongful discharge prohibition found in Section 510 of ERISA. As the Court stated:

> Unquestionably, the Texas cause of action purports to provide a remedy for the violation of a right guaranteed by § 510 and exclusively enforced by § 502(a). Accordingly, we hold that " 'when it is clear or may fairly be assumed that the activities which a State purports to regulate are protected' by § 510 of ERISA, 'due regard for the federal enactment requires that state jurisdiction must yield.' " [*Id.* at 145 (quoting *Lingle* v. *Norge Div. of Magic Chef, Inc.*, 486 U.S. 399, 409 n.8 (1988)).]

So too here, Section 4-10 impermissibly conflicts with ERISA's exclusive remedial scheme. Whereas Congress contemplated that rights under ERISA plans would be determined according to a uniform body of federal common law, Section 4-10 purports to establish a new state law remedy—a form of binding arbitration before an independent

physician—that conflicts with this intent to create an exclusive, uniform national enforcement mechanism. As the Court held in *Pilot Life*, "[t]he expectations that a federal common law of rights and obligations under ERISA-regulated plans would develop * * * would make little sense if the remedies available to ERISA participants and beneficiaries under 502(a) could be supplemented or supplanted by varying state laws." *Id.* at 56. Thus, state laws—like Section 4-10—which attempt to supplement or supplant this federal enforcement scheme with additional or alternative means of determining rights to benefits under ERISA plans, necessarily destroy both the exclusivity and uniformity intended by Congress. Section 4-10 is therefore preempted.[6]

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[6] Affirming the decision below would also pose the troubling situation of a federal cause of action (under Section 502(a)) governed entirely by state law (under Section 4-10). Congress " 'intended that a body of Federal substantive law [would] be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans.' " *Pilot Life*, 481 U.S. at 56 (quoting 120 Cong. Rec. 29942 (1974) (Sen. Javits)). That "body of Federal substantive law" satisfies the Article III "arising under" requirement in the typical 502(a) case. *See Textile Workers Union* v. *Lincoln Mills*, 353 U.S. 448, 456-457 (1957). In a case under Section 4-10, however, the question of rights and obligations under the plan has been vested by state law in the independent reviewer. There is no call for the development or application of a "body of Federal substantive law;" all that the federal court hearing a Section 502(a) case invoking Section 4-10 need do is apply what the actor vested with authority under state law has determined. What is left for the federal court is "only rubber-stamp work;" from all that appears the court is simply "to enter a judgment pursuant to a decision the court has no authority to evaluate." *Gutierrez de Martinez* v. *Lamagno*, 515 U.S. 417, 429-430 (1995). That is in fact what the Court of Appeals did here. *See* Pet. App. 24a ("Dr. Dellon determined * * * that the surgery performed by Dr. Terzis was 'medically necessary.' Thus, Ms. Moran is entitled to summary judgment."). Under the decision below, Section 502(a) simply confers federal court jurisdic-

B. The Court Of Appeals' Reasoning, If Adopted, Would Completely Subvert Congress' Intent To Establish Uniform, Exclusive Federal Remedies

The Court of Appeals correctly recognized that even if a state law would otherwise be within the scope of ERISA's saving clause, such a law "nevertheless may be preempted if that law conflicts with a substantive provision of ERISA." Pet. App. 19a. But the court nonetheless held that Section 4-10 "cannot be characterized as creating an alternative remedy scheme that conflicts with § 502(a)." *Id.* at 21a. According to the court, no conflict exists because Section 4-10 "simply adds to the contract, by operation of law, an additional dispute resolving mechanism," which can then be enforced through an ERISA action under Section 502(a)(1)(B). *Id.* at 22a.

This reasoning, if accepted, would nullify Congress' intent to establish uniform, exclusive federal remedies under ERISA. Of the approximately 124 million people covered by ERISA plans, it is estimated that more than 70 million are covered by fully insured plans.[7] Yet under the Court of

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tion over a suit for the enforcement of state law. As this Court explained in *Mesa* v. *California*, 489 U.S. 121, 136 (1989), "pure jurisdictional statutes which seek 'to do nothing more than grant jurisdiction over a particular class of cases' cannot support Art. III 'arising under' jurisdiction." (quoting *Verlinden B.V.* v. *Central Bank of Nigeria*, 461 U.S. 480, 496 (1983)).

To permit a federal court to entertain a purportedly federal cause of action that is predicated entirely on state law—as did the Seventh Circuit—would thus raise the most troubling constitutional questions under Article III. The statute should be interpreted to avoid such a result, by reaffirming the Court's precedents holding that ERISA preempts state laws that seek to supplant its exclusive remedies. *See Mesa*, 489 U.S. at 137 (declining to adopt reading of statute which "raises serious constitutional doubt").

[7] *See* Karen A. Jordan, *Preemption of a State "Legislatively Created" Right to Sue HMOs for Negligence*, Health Care Law Monthly 13 (Apr. 1999) (estimating 124 million workers insured by ERISA plans); Self-Insurance Inst. of America, Inc., *Self-Insured Health Plans: Questions and Answers*, *reprinted at* http://www.siia.org/public/articles/index.cfm?Cat=24 (estimating 50 million workers covered by self-insured ERISA plans).

Appeals' reasoning, any State could circumvent ERISA's exclusive remedies for insured plans simply by deeming any alternative state law remedy to be a term of the plan. As Judge Posner noted, the Court of Appeals' reasoning "invites states to evade the preemptive force of ERISA simply by deeming [their] regulations of ERISA plans to be plan terms." Pet. App. 27a.

Here, the additional remedy consists of binding de novo arbitration before an independent physician. But under the reasoning of the court below, States could require claims for benefits to be decided by state court juries, state court judges, administrative bodies, or any other decisionmaker, simply by requiring plan administrators—as a new state-mandated term of the plan—to abide by such determinations. States could likewise require insured plans to abide by the decision of a jury awarding punitive or treble damages for wrongfully denied benefits—a result forbidden by ERISA, *see Massachusetts Mut. Life Ins. Co.* v. *Russell*, 473 U.S. 134 (1985)—simply by mandating such a result as a term of the plan. States could direct benefits decisions to be made by a panel of other patients according to state law tort rules. In fact, States could save from preemption *any* alternative remedies through the linguistic sleight-of-hand of providing that their remedies are to be incorporated as plan terms.[8]

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[8] The Seventh Circuit observed in a footnote that the Certificate defining Moran's rights under the plan "incorporated" Section 4-10 by stating that " 'if the provisions of this Certificate do not conform to the requirements of any state or federal law that applies to the Certificate, the Certificate is automatically changed to conform with the requirements of that law.' " Pet. App. 21a n.4 (quoting Certificate). But if ERISA preempts state law, that law

This Court has made clear that States cannot frustrate the core purposes of ERISA so easily. In *Fort Halifax*, *supra*, the Court considered whether ERISA preempted a state law mandating severance benefits. Although the Court found no preemption because the law did not relate to an ERISA plan, the Court expressly rejected the rationale of the lower court—that a State could avoid ERISA preemption simply by mandating a particular employee benefit plan. 482 U.S. at 16-17. As the Court held, such an approach "would permit States to circumvent ERISA's pre-emption provision, by allowing them to require directly what they are forbidden to regulate." *Id.* at 16. Such a rule would "pose a formidable barrier to the development of a uniform set of administrative practices" because employers "would face the prospect that numerous other States would impose their own distinct requirements—a result squarely inconsistent with the goal of ERISA preemption." *Id.* at 17.[9]

The same frustration of ERISA's central goal would occur if States were permitted to circumvent ERISA preemption simply by recasting prohibited alternative remedies as

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does not "appl[y] to the Certificate" and is not incorporated into the plan. *See Light* v. *Blue Cross & Blue Shield of Ala., Inc.*, 790 F.2d 1247, 1248 (5th Cir. 1986) (rejecting same argument and holding that "[i]f ERISA pre-empts state law, there is no applicable state law to which the [plan] administrator must conform"); *see also Heidelberg* v. *National Found. Life Ins. Co.*, 2001 WL 238211, at *2 (E.D. La. Mar. 6, 2001) ("allow[ing] a boiler-plate provision * * * to replace federal law with state law in every respect * * * would undermine the purpose of ERISA's preemption provision").

[9] In *UNUM*, 526 U.S. at 376, the Court held that an ERISA plan cannot "displace any state regulation simply by inserting a contrary term in plan documents." A similar principle applies to States. While plans cannot avoid valid state regulation simply by inserting contract terms, a State cannot use the same tactics to save invalid state regulation.

mandated contract terms. "[D]iffering state regulations affecting an ERISA plan's 'system for processing claims and paying benefits' impose 'precisely the burden that ERISA pre-emption was intended to avoid.' " *Egelhoff*, 121 S. Ct. at 1329 (quoting *Fort Halifax*, 482 U.S. at 10). Faced with a hodgepodge of alternative state remedies disguised as additional plan terms, administrators of nationwide ERISA plans could no longer develop a uniform medical necessity standard or predict with any degree of certainty the financial consequences of coverage decisions. As this Court has held, allowing States to "develop different substantive standards applicable to the same employer conduct, requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction" is "fundamentally at odds with the goal of uniformity that Congress sought to implement." *Ingersoll-Rand*, 498 U.S. at 142. *See also Egelhoff*, 121 S. Ct. at 1328 ("Requiring ERISA administrators to master the relevant laws of 50 States and to contend with litigation would undermine the congressional goal of 'minimiz[ing] the administrative burdens * * * ultimately borne by the beneficiaries.' ") (quoting *Ingersoll-Rand*, 498 U.S. at 142).

The result of this "patchwork scheme of regulation" would be "considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them." *Fort Halifax*, 482 U.S. at 11. *See also FMC Corp.* v. *Holliday*, 498 U.S. 52, 60 (1990) (disuniformity produces "inefficiencies that employers might offset with decreased benefits"). Given the prospect that independent physicians in one State, or administrative tribunals in another, or juries in a third, may decide medical necessity differently from the plan's fiduciary and may award varying forms of relief, employers will have no choice but to reduce benefits or increase premiums. *See* Pet. App. 26a (Posner, J., dissenting from denial of rehearing en banc) (Section 4-10 "adds heavy new procedural burdens to ERISA plans. These

burdens do not come without cost. * * * Piling on costs in the administration of ERISA plans will shrink benefits and deter some employers from offering health insurance at all."). Nor is ERISA's objective of uniform benefit claims administration limited to the interests of employers. ERISA's federal common law scheme also supports the interests of plan participants by promoting fairness and consistency in plan-wide claims adjudication. Section 4-10 plays mischief with this objective by raising the specter of inconsistent and inequitable claims adjudication for participants in the same ERISA plan, depending on the varying judgments of different independent reviewers in different States.

In devising its rule, the Court of Appeals relied on this Court's precedents holding that ERISA does not preclude States from regulating the substantive contractual rights of insureds and insurers through mandatory insurance policy provisions that do not conflict with ERISA's own requirements. *See UNUM*, 526 U.S. 358; *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724 (1985). That reliance was misplaced. Neither *UNUM* nor *Metropolitan Life* addressed state laws that conflicted with ERISA's exclusive enforcement scheme. *Metropolitan Life* involved a typical mandated-benefits law, which required insurance policies to include specified mental health benefits. 471 U.S. at 739. The law said nothing about the remedy for seeking that mandated coverage, or any other benefits. *UNUM* involved a rule that prohibited an insurance company from enforcing contractual notice provisions if it was not prejudiced by late notice. That rule, as well, did not purport to supplant ERISA's exclusive remedies. As the Court noted, the preemptive effect of Section 502(a) was "not implicated" in *UNUM*. 526 U.S. at 376. Although the notice-prejudice rule would supply one of the rules of decision in a Section 502(a) action, the participant's remedy remained an action under federal law to determine whether the plan's fiduciary abused the discretion granted to it under the plan. *See* Pet. App. 25a

(*UNUM* involved "typical regulation of insurance rather than anything either special to ERISA plans or likely to be mischievous in its impact on those plans.") (Posner, J., dissenting from denial of rehearing en banc).

This case, by contrast, does not involve a law altering the substantive contractual rights of insureds and insurers. The plan provides coverage for "medically necessary" treatments, and Section 4-10 does not purport to alter that provision, or mandate coverage of other benefits. Rather, Section 4-10 establishes an alternative decisionmaker—the independent physician—to determine whether a particular procedure is "medically necessary" and, therefore, covered under the plan as written. *See Corporate Health*, 220 F.3d at 645 (independent review provisions "are plainly a state regime for reviewing benefit decisions and not a system for implementing a mandated term of insurance regulating a minimal standard of care"). This law is entirely unlike the laws considered in *Metropolitan Life* and *UNUM*, and just like the laws the Court has consistently held conflict with ERISA's exclusive remedies.[10]

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[10] It is immaterial that the remedy created by Section 4-10 consists of a form of compulsory binding arbitration rather than a judicial cause of action. In either instance, allowing state law to operate would impermissibly establish an alternative remedy in place of ERISA's exclusive ones. " '[T]he distinction between rights and remedies is fundamental. A right is a well founded or acknowledged claim; a remedy is the means employed to enforce a right or redress an injury.' " *Lewis* v. *Lewis & Clark Marine, Inc.*, 121 S. Ct. 993, 999 (2001) (quoting *Chelentis* v. *Luckenbach S.S. Co.*, 247 U.S. 372, 384 (1918)). Section 4-10 compels binding arbitration to enforce an ERISA plan beneficiary's putative right to benefits. That is plainly an alternative remedy, even though the independent physician's decision—like the decision of any arbitrator—is enforceable through a subsequent judicial action. As this Court has held, when a party voluntarily agrees to arbitration, that party does not forego substantive rights, but instead "submits to their resolution in an arbitral, rather than a judicial, forum."

ERISA "does not go about protecting plan participants and their beneficiaries by requiring employers to provide any given set of minimum benefits," *Travelers*, 514 U.S. at 651, and laws regulating insurance in such a manner are therefore not preempted. But the entire purpose of ERISA is to "control[ ] the administration of benefit plans" through, among other things, a "comprehensive civil enforcement scheme." *Id.* *See Metropolitan Life*, 471 U.S. at 732 (ERISA "established various uniform procedural standards" but "does not regulate the substantive content of welfare-benefit plans"). As this Court has repeatedly held, laws like Section 4-10, which interfere or conflict with that comprehensive enforcement scheme, are necessarily preempted. [11]

II. THE INDEPENDENT REVIEW PROVISION OF THE ILLINOIS HMO ACT IS NOT SAVED BY ERISA'S SAVING CLAUSE

A. Laws That Conflict With ERISA's Exclusive Remedies Are Not Within The Scope Of The Saving Clause

As the Court of Appeals recognized, this Court held in *Pilot Life* that ERISA's saving clause, Section 514(b)(2), 29 U.S.C. § 1144(b)(2), does not save from preemption laws

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Mitsubishi Motors Corp. v. *Soler Chrysler-Plymouth, Inc.*, 473 U.S. 614, 628 (1985). Here, Moran's substantive right is her contractual right to coverage for medically necessary procedures; Section 4-10 simply supplies an alternative means to enforce that right. Section 4-10 therefore conflicts with ERISA's exclusive remedies and is preempted.

[11] This conclusion is entirely consistent with Department of Labor regulations, scheduled to take effect next year, which will govern *internal* appeals of adverse benefit determinations. *See* 65 Fed. Reg. 70,246 (2000) (to be codified at 29 C.F.R. § 2560.503-1 *et seq.*). Those regulations expressly state that *external* review laws, such as the one at issue here, are "beyond the scope of the regulation." 65 Fed. Reg. at 70,254.

that conflict with ERISA's exclusive remedies. *See* Pet. App. 19a; *see also Corporate Health*, 215 F.3d at 538 ("even if the provisions would otherwise be saved, they may nonetheless be preempted if they conflict with a substantive provision of ERISA"). On this point, the Court of Appeals was plainly correct. This Court's precedents are clear that a law which conflicts with ERISA's exclusive remedies is necessarily preempted regardless of whether the law might otherwise fall within the scope of the saving clause.

In *Pilot Life*, the Court held that the "understanding of the saving clause must be informed by the legislative intent concerning the civil enforcement provisions provided by ERISA § 502(a), 29 U.S.C. § 1132(a)." 481 U.S. at 52. Based on this reasoning, the Court rejected the argument that a state law cause of action asserting improper processing of an insurance claim was saved from preemption:

> Considering the common-sense understanding of the saving clause, the McCarran-Ferguson Act factors defining the business of insurance, and, *most importantly, the clear expression of congressional intent that ERISA's civil enforcement scheme be exclusive*, we conclude that [the plaintiff's] state law suit asserting improper processing of a claim for benefits under an ERISA-regulated plan is not saved by § 514(b)(2)(A), and is therefore preempted by § 514(a). [*Id.* at 57.]

See also id. at 57 n.4 ("[w]e conclude that [plaintiff's] state common law claims fall under the ERISA pre-emption clause and are not rescued by the saving clause").

In other words, a state law that conflicts with ERISA's exclusive remedies (or any other provision of ERISA, for that matter) cannot be a law that "regulates insurance" within the meaning of the saving clause. Rather than regulating insurance—an area Congress did not intend for ERISA to regulate—such a law governs the procedural remedies for enforcing rights under ERISA plans—an area Congress very

much intended to be the exclusive province of ERISA. *See Corporate Health*, 215 F.3d at 539 ("the saving clause does not operate if the state law at issue creates an alternative remedy for obtaining benefits under an ERISA plan").

If there were any doubt on that point, the Court dispelled it in *John Hancock Mutual Life Insurance Co.* v. *Harris Trust Savings Bank*, 510 U.S. 86 (1993). In that case, the Court held that ERISA "calls for federal supremacy when the two regimes [federal and state] cannot be harmonized or accommodated." *Id.* at 98. Thus, the Court reiterated that the saving clause cannot save state laws that actually conflict with ERISA's provisions:

> [W]e discern no solid basis for believing that Congress, when it designed ERISA, intended fundamentally to alter traditional preemption analysis. State law governing insurance generally is not displaced, but "where [that] law stands as an obstacle to the accomplishment of the full purposes and objectives of Congress," federal preemption occurs. [*Id.* at 99 (quoting *Silkwood* v. *Kerr-McGee Corp.*, 464 U.S. 238, 248 (1984)).]

See also Boggs v. *Boggs*, 520 U.S. at 844 ("In the face of this direct clash between state law and the provisions and objectives of ERISA, the state law cannot stand. * * * States are not free to change ERISA's structure and balance."). Thus, as the Court emphasized, "[n]o decision of this Court has applied the saving clause to supersede a provision of ERISA itself." *John Hancock*, 510 U.S. at 99 n.9. That is precisely what respondent would have the Court do in this case.

In the fourteen years since *Pilot Life*, Congress has had ample opportunity to change this Court's holding that insurance laws that actually conflict with ERISA are not saved from preemption, but it has not done so. There is therefore no cause for this Court to change course now. *Cf. Illinois Brick Co.* v. *Illinois*, 431 U.S. 720, 736 (1977) ("[W]e must bear in mind that considerations of stare decisis weigh

heavily in the area of statutory construction, where Congress is free to change this Court's interpretation of its legislation."). Nor has the *Pilot Life* rule "proven to be intolerable simply in defying practical workability." *Planned Parenthood of Southeastern Pa.* v. *Casey*, 505 U.S. 833, 854 (1992). Quite to the contrary, the lower courts, while struggling with other aspects of ERISA preemption, have had little difficulty following *Pilot Life*'s command that state laws that conflict with ERISA's exclusive remedies are preempted and not saved by the saving clause.[12] What defies practical workability is not the clear *Pilot Life* rule, but rather the abandonment of that rule, which would relegate all preemption questions regarding insurance laws to the indeterminate balancing of the remaining saving clause factors. *See infra* at 37- 40.

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[12] *See, e.g.*, Pet. App. 19a; *Corporate Health*, 215 F.3d at 538; *Dang* v. *UNUM Life Ins. Co. of Am.*, 175 F.3d 1186, 1191 (10th Cir. 1999); *Gaylor* v. *John Hancock Mut. Life Ins. Co.*, 112 F.3d 460 (10th Cir. 1997); *Smith* v. *Provident Bank*, 170 F.3d 609, 615 (6th Cir. 1999) ("In essence, the test for application of the saving clause is whether the law substantively regulates a relationship or merely provides alternative remedies for harms for which ERISA already provides redress."); *United of Omaha* v. *Business Men's Assurance Co. of Am.*, 104 F.3d 1034, 1041-42 (8th Cir. 1997); *In re Life Ins. Co. of N. Am.*, 857 F.2d 1190, 1194 (8th Cir. 1988) ("The Court in *Pilot Life* could not have stated with any greater clarity that the remedies afforded under ERISA are exclusive, and no state law purporting to supply additional remedies will escape the preemptive effect of § 1144(a) as laws 'which regulate insurance' under § 1144(b)(2)(A)."); *Smith* v. *Jefferson Pilot Life Ins. Co.*, 14 F.3d 562, 570-571 (11th Cir.), *cert. denied*, 513 U.S. 808 (1994); *Tingey* v. *Pixley-Richards West, Inc.*, 953 F.2d 1124, 1132 (9th Cir. 1992); *Kanne* v. *Connecticut Gen. Life Ins. Co.*, 867 F.2d 489, 493-494 (9th Cir. 1988), *cert. denied*, 492 U.S. 906 (1989); *International Resources, Inc.* v. *New York Life Ins. Co.*, 950 F.2d 294, 300-301 (6th Cir. 1991), *cert. denied*, 504 U.S. 973 (1992).

There is good reason why Congress has not seen fit to alter the *Pilot Life* rule. If all laws addressing insurers could be considered laws which "regulate insurance" within the meaning of the saving clause *even* when such laws conflict with ERISA's substantive provisions, then Congress' intent to create uniform federal standards for ERISA plan administration would be rendered chimerical. *See* Explanatory Statement Concerning S. 3589, 116 Cong. Rec. 7284, 7288 (1970) (Congress intended ERISA to be "the exclusive form of regulation for employee benefit plans within the areas covered" by the Act, leaving intact only those state laws "which *otherwise* regulate insurance, banking, or securities") (emphasis supplied). Under such a rule, the saving clause would not simply save state laws which—unlike ERISA—regulate insurance, but rather would swallow ERISA whole.

B. Section 4-10 Is Not, In Any Event, A State Law That "Regulates Insurance"

The remaining tests for application of the saving clause bolster the conclusion that Section 4-10 is not saved from preemption. From a "common sense view of the matter," *Metropolitan Life*, 471 U.S. at 740, Section 4-10 does not "regulate insurance;" it regulates the administrative practices of HMOs. Nor does Section 4-10 satisfy the three factors commonly employed to determine whether a law fits within the "business of insurance" as that phrase is used in the McCarran-Ferguson Act—" '*first*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry.' " *Id.* at 743 (quoting *Union Labor Life Ins. Co.* v. *Pireno*, 458 U.S. 119, 129 (1982) (emphases in original)).

1. The "common-sense view of the word 'regulates' would lead to the conclusion that in order to regulate insurance, a law must not just have an impact on the insurance industry,

but must be *specifically directed toward that industry.*" *Pilot Life*, 481 U.S. at 50 (emphasis added). In *UNUM*, for example, this Court concluded that a state notice-prejudice rule that was " 'directed specifically at the insurance industry and * * * applicable only to insurance contracts' " was saved from preemption. 526 U.S. at 368 (quoting *Cisneros* v. *UNUM Life Ins. Co.*, 134 F.3d 939, 945 (9th Cir. 1998), *cert. denied*, 526 U.S. 1086 (1999)). Similarly, in *Metropolitan Life*, 471 U.S. at 742-743, this Court found that a state mandated-benefit law regulating the substantive content of insurance policies was saved from preemption under the saving clause. *Cf. FMC Corp.* v. *Holliday*, 498 U.S. at 61 (state law which invalidated subrogation provisions of insurance contracts was "aimed at" insurance industry and covered by saving clause).

Section 4-10, however, is not "directed specifically at the insurance industry," *UNUM*, 526 U.S. at 368; it is directed toward HMOs. *See* Pet. App. 25a (Posner, J., dissenting from denial of rehearing en banc) (Section 4-10 "is not a general regulation of insurance, or even of health insurance; it is a regulation of HMOs, which are the service providers under a great many ERISA medical-benefits plans"). The two are not fungible, for the simple reason that not all HMOs offer insurance products, and even those that do offer insurance options do not always bear the risk for the health plans with which they contract. *See* Jonathan P. Weiner & Gregory de Lissovoy, *Razing a Tower of Babel: A Taxonomy for Managed Care and Health Insurance Plans*, 18 J. Health Pol., Pol'y & L. 75, 76, 81 (1993) (hereinafter "Weiner & de Lissovoy"). HMOs have on occasion been described as general "insurance vehicle[s]," *see Anderson* v. *Humana, Inc.*, 24 F.3d 889, 892 (7th Cir. 1994); but it is more accurate to say, as the Solicitor General noted in its brief in *Pegram* v. *Herdrich*, that an HMO only "acts as an insurer to the extent that it bears risk." Br. for United States as Amicus Curiae Supporting Petitioners, No. 98-1949, at 11 n.5. Some HMOs

may "insure, manage, and provide care;" but others are simply "providers and managers; and still others only administer." Weiner & de Lissovoy at 78.

Recognizing that HMOs and other managed care organizations ("MCOs") may not bear risk in all circumstances, some States have enacted statutes regulating MCOs which are limited by their terms to only those entities' insurance functions. *See, e.g.*, *Stuart Circle Hosp. Corp.* v. *Aetna Health Mgmt.*, 995 F.2d 500, 501 (4th Cir. 1993) (statute regulating insurer-operated preferred-provider "health benefit program[s]" saved under saving clause). Section 4-10, however, has no such limits on its scope. The Illinois HMO Act broadly defines HMOs as "*any* organization formed under the laws of this or another state to provide *or* arrange for one or more health care plans under a system which causes any part of the risk of health care delivery to be borne by the organization *or its providers*." 215 Ill. Comp. Stat. § 125/1-2(9) (emphases added). By its terms, that definition captures HMOs that themselves do not bear the "risk of health care delivery," and thus applies broadly to HMOs that act in a purely administrative role and devolve all risk onto their providers[13] or onto a third-party insurer. *Id.*; *see* Weiner & de Lissovoy at 81. Section 4-10 does not further distinguish between risk-bearing and non-risk-bearing HMOs; it applies to "*each* Health Maintenance Organization." 215 Ill.

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[13] *See* E.H. Morreim, *Confusion in the Courts: Managed Care Financial Structures and their Impact on Medical Care*, 35 Tort & Ins. L. J. 699, 705 (2000) (noting that in capitated arrangements, where MCO pays doctors a fixed fee per patient per month, organization "transfers its financial risk" to doctors); *see also Arizona* v. *Maricopa County Med. Soc'y*, 457 U.S. 332, 339 n.7 (1982) (noting that for HMOs in which the "consumer pays a fixed periodic fee to a functionally integrated group of doctors in exchange for the group's agreement to provide any medical treatment that the subscriber might need," "the economic risk is * * * borne by the doctors").

Comp. Stat. § 125/4-10 (emphasis added). The statute thus covers HMOs even when they are not acting as insurers; HMOs acting solely as administrators for a plan or its providers are just as obligated under the statute to submit to independent review of their medical-necessity determinations as HMOs that also function as insurers.[14]

Section 4-10 applies across the board to all HMOs because it does not regulate an HMO's insurance functions. The services targeted by Section 4-10 are administrative services performed by both non-risk-bearing and risk-bearing HMOs alike.[15] The statute purports to regulate HMOs' administration of benefit plans by directing them to comply with a third, external level of review of their medical necessity decisions. The law certainly affects HMOs acting as insurers, just as it affects HMOs that only administer a plan; but a state law otherwise preempted under ERISA is only saved by the saving clause if it regulates *insurance*, not *insurers*. *See Group Life & Health Ins. Co.* v. *Royal Drug Co.*, 440 U.S. 205, 217 (1979) ("The exemption is for the 'business of insurance,' not the 'business of insurance companies.' "). Section 4-10 may impact some insurers – but it does not regulate insurance. *See Prudential Ins. Co. of Am.* v. *National Park Med. Ctr., Inc.*, 154 F.3d 812, 829 (8th Cir. 1998)

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[14] Another section of the Act likewise confirms that HMOs include entities operating as other than insurers: Section 2-3 of the Act grants HMOs the power to "contract[ ] with an insurance company * * * for the provision of insurance, indemnity, or reimbursement against the cost of health care service provided by the Health Maintenance Organization." 215 Ill. Comp. Stat. § 125/2-3.

[15] Administration of a health benefit plan includes "claims services, utilization review, auditing, plan design consulting, contracting for excess risk coverage, client reports, [and] record keeping." Self-Insurance Institute of America, Inc., *Facts About Self-Insurance of Health Benefits* 4 (1994). Third-party administrators manage plans covering more than 56 million employees. *Id.*

(state law "directed at regulation of broadly defined health benefit plans, only some of which fall within the insurance industry," not saved under ERISA saving clause); *Texas Pharm. Ass'n* v. *Prudential Ins. Co. of Am.*, 105 F.3d 1035, 1039 (5th Cir.) (finding state "any willing provider" law preempted and not saved, where MCOs were subject to requirement regardless of whether an insurer was involved), *cert. denied*, 522 U.S. 820 (1997).

2. a. Section 4-10 also fails to satisfy any of the three McCarran-Ferguson factors, which are used as "checking points or guideposts" in the saving clause inquiry. *UNUM*, 526 U.S. at 374. First, the law does not have the effect of transferring or spreading risk—an "indispensable characteristic" of the business of insurance. *Royal Drug*, 440 U.S. at 211-212.[16] As this Court explained in *Pireno*, transfer of risk occurs "at the time that the [insurance] contract is entered;" the policy "defines the scope of risk assumed by the insurer from the insured." 458 U.S. at 130-131. When a policy limits coverage to "medically necessary" treatments, "that limitation is the measure of the risk that has actually been transferred to the insurer." *Id.* at 130. An insurance law spreads risk only if it changes the substantive terms of the insurance contract by mandating certain benefits or expanding the services offered by the terms of the contract. *See Metropolitan Life*, 471 U.S. at 731, 743 (mandated-benefits statute spreads risk of mental health coverage to larger pool of insurance risks); *see also Smith* v. *Jefferson Pilot Life Ins. Co.*, 14 F.3d 562, 569-570 (11th Cir. 1994) (examining whether statute "affect[s] the apportionment of risks, *i.e.*, what medical costs are covered, that the parties made upon entering the contract").

[16] The panel below did not dispute that Section 4-10 did not spread risk. *See* Pet. App. 18a n.3. *See also Corporate Health*, 215 F.3d at 538 (independent review provisions "probably do not meet the first factor of reallocating the risk between the insured and insurer," though that failure not regarded as determinative).

Section 4-10 does not alter or redistribute the risk of medical services among plan enrollees; it enforces the risk already negotiated, by adding an (impermissible) alternative avenue of review of an HMO's benefits decision. With or without Section 4-10, Rush must pay for medically necessary procedures. Nothing about Section 4-10 changes that standard or grants enrollees broader coverage rights.[17]

b. For similar reasons, Section 4-10 fails to satisfy the second McCarran-Ferguson factor. The provision is not an "integral" part of the policy relationship between insurer and insured, because it does not "define the terms of th[at] relationship." *Pilot Life*, 481 U.S. at 51. The terms of the relationship between insurer and insured—including the "medically necessary" standard for determining coverage—are established in the plan and unchanged by Section 4-10. Section 4-10 simply offers a different avenue by which a beneficiary can enforce those terms. *See Pireno*, 458 U.S. at 131 (insurer's use of peer review committee not an "integral part of the policy relationship between insurer and insured," despite committee's "interpretation and enforcement of the insurance contract") (quotation omitted). The notice-prejudice rule in *UNUM*, in contrast, "dictate[d] the terms of the relationship between the insurer and insured," because it substantively altered the bargain between the two by "requiring an insurer to prove prejudice before enforcing a timeliness-of-claim provision." 526 U.S. at 374-375.

[17] It is of course true that Section 4-10 would require HMOs to bear costs in particular cases that they otherwise would not bear. The same is true of the remedies provided by ERISA. Viewing that possibility as "risk-spreading" under the first McCarran-Ferguson factor proves too much; shifting incremental costs is not the same as spreading risk. *See Cisneros* v. *UNUM Life Ins. Co.*, 134 F.3d at 946 (state notice-prejudice law "shift[s] the risk of lost coverage" depending on the timing of a claim, but "does not alter the allocation of risk for which the parties originally contracted") (citing *Pireno*, 458 U.S. at 130).

Section 4-10 does not require Rush to prove anything other than what the plan already requires. It just changes the decisionmaker who is to determine the contractual issue.

c. Finally, Section 4-10 does not satisfy the third McCarran-Ferguson factor—whether the law is "limited to entities within the insurance industry," *UNUM*, 526 U.S. at 375—for the same reason that it fails the common sense test. The law applies to HMOs regardless of whether they act as insurers or third-party administrators.

Far from a "typical regulation of insurance"—like the notice-prejudice rule at issue in *UNUM*—Section 4-10 is directly aimed at ERISA plan administration and is "likely to be mischievous in its impact on those plans." Pet. App. 25a (Posner, J., dissenting from denial of rehearing en banc). It does not spread risk. It does not add a substantive benefit to the plan. It does not apply solely to insurance entities. It merely creates an alternative remedy for plan beneficiaries to seek benefits they claim they are owed under the plan. That is precisely what ERISA exclusively regulates under Section 502(a). The "extraordinary pre-emptive power" of Section 502(a), *Taylor*, 481 U.S. at 65, bolstered by application of the common-sense and McCarran-Ferguson tests, requires a finding that Section 4-10 is preempted by ERISA.

3. At the same time, it cannot be denied that answering the question whether a state law "regulates insurance" under the saving clause is far more difficult than it should be, particularly for such a threshold issue as preemption. The difficulties began with what this Court has noted is not a paragon of legislative draftsmanship. *See, e.g., John Hancock*, 510 U.S. at 99 ("ERISA's preemption and saving clauses ' "are not a model of legislative drafting," ' and the legislative history of the provision is sparse.") (quoting *Pilot Life*, 481 U.S. at 46, quoting *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. at 739). Add a multi-factor balancing test incorporating "common sense" (as only one factor to consider, to be sure)

and the concededly indefinite McCarran-Ferguson factors—not all of which need be satisfied and no one of which is determinative, *UNUM*, 526 U.S. at 373-374—and the goal of reasonable predictability in the law becomes increasingly elusive.

Nor is the problem limited to legislative draftsmanship and "supple" precedent. *Id.* at 373. Changes in the underlying industry have strained once-familiar categories and contributed to the endemic uncertainty. When ERISA was enacted, one health insurance arrangement predominated in the market: traditional indemnity insurance plans. *See* Weiner & de Lissovoy at 76. In the early 1980s, approximately ninety percent of working Americans covered under insurance plans were covered by indemnity plans; five percent participated in a prepaid HMO during the same period. *Id.* at 76-77. Over the next decade, as employers attempted to manage sharply rising health care costs, the industry underwent a massive change; "[b]y 1990, conventional (i.e., unmanaged) indemnity health insurance policies no longer covered the majority of Americans." *Id.* at 77. As they grew in popularity, HMOs and other MCOs began in some circumstances to act as provider and insurer; and as indemnity insurance companies sought to contain their own costs, some began to take on the characteristic features of an HMO. *See Corporate Health*, 215 F.3d at 531 (noting that as managed care organizations grew in popularity, "at the same time, the insurance industry began to offer administrative services to employers and to contract with doctors for services at set rates").

Poorly drafted laws, multi-factor balancing tests, and a blurring of pertinent distinctions in the health insurance industry have combined to form the present prescription for generating circuit conflicts, causing this area of the law to

demand far more of this Court's attention than it deserves.[18] The indeterminacy itself goes far to undermine ERISA's goal of establishing a " 'uniform body of benefits law' " for ERISA plans. *Travelers*, 514 U.S. at 656 (quoting *Ingersoll-Rand*, 498 U.S. at 142).

Yet amidst this roiling sea lies a rock island of certainty and stability. ERISA's remedies are exclusive, notwithstanding the saving clause. That is what this Court held in *Pilot Life*. However you interpret the saving clause, however many factors you weigh, at the end of the day the "most important[]" is "the clear expression of congressional intent that ERISA's civil enforcement scheme be exclusive." *Pilot Life*, 481 U.S. at 57. Section 4-10 does not add a new, substantive coverage term to an insurance policy, like the mandated-benefit provision in *Metropolitan Life*. It creates a new remedy to enforce the terms of an ERISA benefit plan, just like the laws found preempted and not saved by the saving clause in *Pilot Life*. A state law inventing a new remedy for ERISA plan beneficiaries directly conflicts with ERISA; basic federal supremacy principles forbid that result. *See John Hancock*, 510 U.S. at 99; *Ingersoll-Rand*, 498 U.S. at 144; *Pilot Life*, 481 U.S. at 52. The Court should cling to what certainty there is in this area and hold that Section 4-10 is therefore preempted.

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[18] Since the Court noted in 1997 that it had been compelled to hear 16 ERISA preemption cases between 1974 and the 1996 Term, *De Buono*, 520 U.S. at 808 n.1, at least three more have been added to the list—*UNUM*, *Egelhoff*, and this case. Other ERISA preemption conflicts continue to brew in the lower courts. *See, e.g.*, Justin Goodyear, Note, *What Is An Employee Benefit Plan? ERISA Preemption Of "Any Willing Provider" Laws After* Pegram, 101 Colum. L. Rev. 1107, 1117 (2001) (noting "broad[ ]" circuit split on issue whether state "Any Willing Provider" laws are preempted under ERISA or saved by insurance saving clause).

CONCLUSION

For the foregoing reasons, the judgment below should be reversed.

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IN THE

Supreme Court of the United States

RUSH PRUDENTIAL HMO, INC.,

Petitioner,

v.

DEBRA C. MORAN and STATE OF ILLINOIS,

Respondents.

ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

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QUESTIONS PRESENTED

Whether Section 4-10 of the Illinois Health Maintenance Organization ("HMO") Act, 215 Ill. Comp. Stat. 125/1 through 6 (2001), which requires "independent review" of certain decisions by HMO insurers, "relates to" an ERISA benefits plan within the meaning of ERISA's preemption provision, 29 U.S.C. § 1144(a), in instances where the HMO insurance is sold to an ERISA plan or plan sponsor to provide plan benefits.

Whether ERISA's saving clause for state laws that regulate insurance, 29 U.S.C. § 1144(b)(2)(A), saves the Illinois statute from any preemption when the HMO insurance is sold to an ERISA benefit plan or plan sponsor.

Whether, regardless of ERISA preemption, independent review is required in this case because the HMO insurance policy voluntarily incorporated Section 4-10 of the Illinois HMO Act as a policy term.

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STATEMENT OF THE CASE

Respondent Debra C. Moran ("Moran") suffered from radial brachial plexopathy and thoracic outlet syndrome, two combined, painful and debilitating conditions in her right shoulder. She sought treatment from her HMO insurer's designated "primary care" physician, Dr. LaMarre, within the HMO insurance network of petitioner, Rush Prudential HMO, Inc. ("Rush"). Pet. App. 3a-4a. This HMO insurance coverage was purchased and provided as an employee benefit through Moran's husband's employer. The HMO coverage was a fully insured benefit under the plan established by the employer. Pet. App. 3a.[1]

Moran was treated conservatively and referred within network for specialist consultation. Pet. App. 4a. She did not improve. When Dr. LaMarre could offer no further in-network treatment, Moran sought further treatment herself outside the network. R.58, 12(n), ¶¶1(g)-(m).[2] She located a

1. Rush and its amicus attempt to obscure the basic distinction between Rush as an HMO insurer and the employer's ERISA-covered benefit plan. Their briefs equate the two and even refer to Rush's insurance certificate as the "plan." *E.g.*, Pet. Br. 4, 8, 13, 15, 17; Amicus Br. 2, 7, 26. In fact, Debra Moran's husband's employer provided an employee welfare plan benefit to its employees and their spouses pursuant to which the plan paid for covered medical expenses. Pet. App. 3a. That employer contracted with Rush to fully insure plan benefits through the means of HMO insurance. Pet. App. 3a.; R.38, Ex. A, p. 7. Rush admits it was licensed to do business as an insurer in Illinois and that the provisions of the Illinois HMO Act, including "Section 4-10," the independent review law, applied to it. R.58, 12(n), ¶¶ 45-46. Rush provides no evidence that its insurance certificate is an ERISA "plan," and the certificate in fact lacks many requisite elements of an ERISA plan. *See infra*, pp. 16-18.

2. Rush states that "[Dr.] LaMarre began to treat Moran with physiotherapy. While she [Moran] was still undergoing this treatment, (Cont'd)

surgeon in Virginia, Dr. Terzis, who specializes in treating this rare combination of conditions, and she sought Rush's approval to see Dr. Terzis for a specialty consultation. Rush refused. Pet. App. 4a. Moran made and paid for the trip and consultation herself. Dr. Terzis recommended surgery, including rib resection, scalenectomy and, upon surgical exploration, microneurolysis if necessary. She told Moran that she had successfully treated these conditions before; she had a high success rate; and there was a low chance of a significant adverse outcome. Pet. App. 4a; R.58, 12(n), ¶1(n); R.75, 12(n), Suppl. ¶¶68, 71.

Moran requested Rush's approval for Dr. Terzis's proposed out-of-network surgery. Instead, Dr. LaMarre requested that she see some additional in-network specialists. She did. Dr. Dieter recommended the conservative treatment of rib resection and scalenectomy only, and told Moran she had *a one-third chance of significant adverse outcome, including potential paralysis or loss of limb*. Pet. App. 5a; R.58, 12(n), ¶1(n)-(g). Dr. Warren could reach no definitive conclusion or recommendation.[3] *Id.* In view of the significant potential adverse outcome presented by Dr. Dieter's proposed surgery, Moran wanted the safer surgery proposed by Dr. Terzis. Pet. App. 5a; R.58, 12(n), ¶6.

(Cont'd)
Moran sought the opinion of Dr. Julia Terzis, an out of network surgeon in Virginia." Pet. Br. 9. In fact, Moran sought Dr. Terzis's advice because Dr. LaMarre's conservative treatment was not working, her symptoms were progressively worsening, and Dr. LaMarre could offer no other treatment option. R.58, 12(n), ¶1(g)-(m).

3. Drs. Warren and Dieter were in-network affiliated physicians with Rush. Prior to Moran's surgery, no independent physician reviewed Rush's denial of her request for coverage for that surgery. R.58, 12(m), Response, ¶9.

Dr. LaMarre recommended approval of Dr. Terzis's proposed surgery because Moran would be "best served" by having Dr. Terzis's procedure performed. Pet. App. 5a. CENTRA's medical director, a physician, on behalf of the organization responsible for physician services under Rush's insurance contract, also approved Dr. Terzis's proposed services as medically necessary. R.58, 12(n), ¶1(s). Notwithstanding those recommendations, Rush refused to approve the treatment. This refusal was based solely on the reason that it was out of network. Pet. App. 5a. Moran appealed the denial under Rush's insurance contract guidelines. Pet. App. 5a. Rush still refused to approve the proposed treatment, now claiming it was not "medically necessary" because there purportedly was no peer review evidence of the procedure's safety and efficacy, and because Dr. Terzis supposedly made no showing of its successful use in patients without direct trauma to the shoulder. R.58, Exhibits (d)-(f).[4] After exhausting the initial review procedures under the insurance contract with Rush, Moran requested that Rush provide her with an independent review of the medical necessity of the proposed treatment as required by the Illinois HMO Act. Pet. App. 6a. Rush refused to provide independent review under the Illinois statute, claiming review of its medical necessity decision as an insurer was preempted by ERISA. R.1.[5]

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4. There is no evidence that Rush required any such showings for the in-network surgery proposed by Dr. Dieter.

5. Rush states that:

> having exhausted the various review procedures provided *in the benefit plan*, without obtaining a favorable ruling on medical necessity, Moran could have pursued the remedy afforded by ERISA. . . . In such an action, Rush's determination pursuant to *plan* procedures that the Terzis surgery was not medically necessary should be set aside

(Cont'd)

Moran filed a suit for declaratory judgment in the Circuit Court of Cook County, seeking appointment of an independent review physician and enforcement of the Illinois independent review law. Pet. App. 7a. She also sought a temporary restraining order to enforce application of that law because her condition was worsening and she was in need of immediate medical treatment. R.1, Ex. B. Rush removed to Federal court on the basis of complete preemption under ERISA. Pet. App. 7a.

After that removal, in early February 1998, because Moran's pain and disability were increasing, she and her husband borrowed money from their 401(k) retirement plans, took personal loans, and Moran had the surgery performed by Dr. Terzis. The surgery was successful, and Moran is now pain free and fully functional. R.58, 12(n), ¶¶3-4.

Dr. Terzis testified that upon surgical exploration, she found significant nerve pathology. She concluded that Moran needed microneurolysis and Dr. Terzis performed it. R.75, ¶¶75-76 and Ex. C. Dr. Terzis concluded that Moran would probably have suffered an adverse outcome and less successful clinical results had Dr. Terzis not performed the microneurolysis when she did. R.75, ¶77.

(Cont'd)

> only if the court — applying standards developed under ERISA's body of federal common law — determined that it constituted an abuse of discretion.

Pet. Br. 10 (emphasis added). This is not a statement of any "fact" below. Rush is not the "plan." It is an insurer of one benefit — health coverage — that is provided by the plan. Pet. App. 3a. Moreover, Moran had not yet exhausted the review procedures of Rush's *insurance contract* because that contract expressly adopted Illinois law, which required independent review (R.38, Ex. A, p. 34). *See infra* at 46-48.

Moran moved to remand her lawsuit to state court on the basis that her complaint sought enforcement of a state statute regulating insurance and thus was saved from ERISA preemption. Pet. App. 7a. The district court granted the motion and remanded the case in June, 1998 on the basis that any potential preemption did not provide an independent basis for federal jurisdiction. Pet. App. 7a.

The state court granted Moran's motion for judgment on the pleadings in part, finding the independent review portion of the Illinois law not preempted by ERISA, and ordering immediate independent review. Pet. App. 7a. Pursuant to the state court's order, the parties agreed on Dr. Dellon at John Hopkins University as the independent reviewer.

Rush states that the independent review physician "concluded that the surgery was medically necessary, while noting that he would have used a less intrusive and less time consuming procedure." Pet. Br. p. 11. In fact, Dr. Dellon's independent review report found in pertinent part:

> Based on Dr. Terzis's intra operative reporting, what she did was appropriate to C5, 6, 7, 8 and T-1 cords fibrous roots. Based upon the work reviewed, Moran had all the indications and therefore the medical necessity to carry out a supra clavicular brachial plexus neurolysis, including microneurolysis and removal of the first rib as done.

R.38, Ex. G. Dr. Dellon also noted that "based on Moran's preoperative medical record, I would have done the same type of surgery that Dr. Terzis performed." *Id.* He also concluded that it is the prevailing opinion within the appropriate specialties that microneurolysis is safe and

effective for its intended use on thoracic outlet syndrome patients with Moran's medical history, and "it is the opinion of those people who do significant peripheral nerve surgery that failure to remove scar tissue from around nerves or nerve roots would adversely affect the patient's medical condition." *Id.* He concluded that:

> [I]f I had been the treating physician for Debra Moran, I would have done the same operation that Dr. Terzis undertook, and I believe that most surgeons experienced with peripheral nerve surgery would have done so. The surgery she did and the approach she took minimized the risk of injury to the intercostal brachial nerve, the possibility of pneumothorax, damage to the subclavian artery and vein and direct damage to nerve roots, all of which are well-known complications in the transaxillary approach. Furthermore, the transaxillary approach has a high failure rate with subsequent surgery being required through a supra clavicular approach.

Id.

Despite the results of this independent review, Rush refused to reimburse Moran for the money she spent to obtain the surgery, hospitalization, and follow-up care needed to repair her shoulder. Pet. App. 8a. Moran filed her first amended complaint which prayed for an order that Rush pay for the expenses of the surgery. Pet. App. 8a. Rush removed again. Pet. App. 8a.

Moran again moved to remand. Pet. App. 8a. The district court denied remand, now concluding the Illinois independent review law does not regulate insurance and is not saved from ERISA preemption. R.37. The court refused to reconsider

based on this Court's decision in *UNUM Life Insurance Co. v. Ward*, 526 U.S. 358 (1999), and ruled that the deemer clause applied, 29 U.S.C. § 1144(b)(2)(B), thereby avoiding the effect of the insurance saving clause, 29 U.S.C. § 1144(b)(2)(A), even though this was a fully insured plan. Pet. App. 8a-9a.

Moran filed a second amended complaint, adding in the alternative counts under ERISA for breach of contract and violation of the Illinois HMO Act as incorporated into the Rush insurance contract by its terms, and for breach of fiduciary duty. These counts sought reimbursement for the money she paid to get treatment, along with prejudgment interest, attorneys' fees and costs. Pet. App. 9a-10a.

Rush admitted it is a licensed Illinois HMO providing medical services to patients in Illinois and that the provisions of the Illinois HMO Act, including Section 4-10, apply to it. R.58, 12(n), ¶¶45-46. Rush's HMO insurance policy here specifically provided:

> If the provisions of this certificate do not conform to the requirements of any state or federal law that applies to this certificate, the certificate is automatically changed to conform with the requirements of that law.

R.38, Ex. A, p. 34. Rush conceded below that if it specifically incorporated the Illinois HMO Act into its policy, Section 4-10 would apply despite ERISA, and that it had no refuge under ERISA if the independent reviewer found medical necessity. R.33, Ex. I, pp. 15-16. However, the district court granted Rush's motion for summary judgment and denied Moran's cross-motion, ruling that Section 4-10 was preempted by ERISA. Pet. App. 10a.

On the motions for summary judgment, Moran provided numerous facts relating to the alternative count for breach of fiduciary duty. R.58, R.75-76. The HMO administrator who denied coverage admitted that among all of the proposed surgeries for Moran, there was no prevailing opinion as to whether any particular surgery was safer and more effective than any other, and he admitted that Dr. Terzis's surgery was one of the possible approaches. R.58, 12(n), ¶22. He refused to accept the independent reviewer's opinion that the length of time of surgery cannot *per se* be related to medical necessity or choice of type of operation. R.58, 12(n), ¶49. He understood that microneurolysis was safe and effective but still denied coverage. R.58, 12(n), ¶51. He understood the independent reviewer believed it is the opinion of those people who do significant peripheral nerve surgery that failure to remove scar tissue around nerves or nerve roots would adversely affect the patient's medical condition, but denied coverage because he claimed there was no evidence that the failure to have the nerve surgery and to remove the scar tissue would adversely affect Moran's medical condition. He understood also the reviewer's statement that "based on Dr. Terzis's intra operative reporting, what she did was appropriate to C-5, 6, 7, 8 and T-1 cords fibrous roots," but nevertheless denied coverage claiming there was no evidence the procedure was safe and effective for its intended use. R.58, 12(n), ¶¶53-54; Ex. G.

Rush tells this Court that "after reviewing Dr. Dellon's report and reports from three other physicians reaching the opposite conclusion, Rush again denied Moran's claim on the ground that the surgery was not medically necessary." Pet. Br. p. 11. Two of the surgeons were affiliated with Rush and admittedly had no expertise in the area. Pet. App. 6a. Rush did have a third physician review the surgery on an *ex parte* basis. Pet. App. 6a. At the time of Rush's second denial it had five opinions: the opinion of its own primary

care physician that Moran should have Dr. Terzis's surgery; the opinion of the medical director of CENTRA, its physician services provider, that Dr. Terzis's surgery was medically necessary; Dr. Terzis's opinion that the pathology present confirmed it was indicated and necessary; Dr. Dellon's "independent review" opinion that the successful surgery was medically necessary; and the opinion of its own hired physician obtained *ex parte*. Rush chose its hired doctor's opinion without explanation. R.58, 12(n), ¶22.

On appeal, the Seventh Circuit reversed, holding that Section 4-10 is not preempted by ERISA and that Moran was entitled to judgment because the state-mandated independent review determined her surgery was medically necessary. Pet. App. 1a-24a. Holding that the district court should be reversed on that basis alone, the court of appeals did not reach Moran's appeal of summary judgment on her breach of fiduciary duty claim. *Id.*

SUMMARY OF ARGUMENT

I. An HMO insurer's "medical necessity" decisions should be decided on an objective basis because insurers have an inherent self-interest in denying coverage. Independent review provides fair, effective and objective review. Rush chose to operate its HMO insurance business in Illinois subject to Illinois state insurance regulations, including the Illinois independent review law. Illinois regulates all HMO insurers in Illinois, regardless of the identity of the insured, by requiring independent review of disputed medical necessity decisions.

II. The Illinois independent review law is not preempted by ERISA because it regulates the HMO insurance contract, not the employee benefit plan. Rush fails to meet its burden of proof on the affirmative defense of preemption. The Illinois

law does not "relate to" an ERISA plan because it does not "refer to" such a plan, it does not act immediately and exclusively upon an ERISA plan, and the existence of an ERISA plan is not essential to the law's operation. Moreover, the Illinois law does not have "a significant connection with" an ERISA plan because it does not dictate the choices an ERISA plan makes. Preemption does not occur if the state law has only a remote or peripheral connection with covered plans. That is the case here. The statute does not compel an ERISA plan to do anything. Rather, independent review is required for all HMO insurance, regardless whether the purchaser of the insurance is an ERISA plan or anyone else, and an ERISA plan (or plan sponsor) merely makes a decision whether or not to buy that insurance.

III. In any event, the Illinois law "regulates insurance" within the meaning of ERISA's saving clause and is saved from preemption. The Illinois law meets all of the relevant factors for determining whether it "regulates insurance" within the meaning of the saving clause. First, it regulates insurance as a matter of common sense, because it is by its terms directed specifically at the insurance industry and is applicable only to HMO insurance contracts. The Illinois law does not just have an impact on the insurance industry, it is specifically aimed at it. This conclusion is consistent with Illinois and Federal law that HMOs are insurers and with this Court's precedent, as well as with the statutory history of the Federal HMO Act and ERISA.

Second, the Illinois law also meets the McCarran-Ferguson factors for determining whether a regulation fits the "business of insurance." The statute mandates a contract term between the HMO and its policyholders and insureds, and is integral to the insurer/insured relationship. Thus, the law meets at least two of the McCarran-Ferguson factors. It also operates to spread risk, acting on an individual basis just like the California notice-prejudice rule this Court found not preempted in *UNUM*.

Application of the Illinois insurance law is consistent with the Court's decisions permitting direct State regulation of insurance voluntarily purchased by ERISA plans and sponsors, including both substantive and procedural insurance requirements. Further, any effect the law may have on cost or uniformity is irrelevant and not a basis for avoiding the saving clause, as any such effect is the result of Congress' decision to save local insurance regulation.

IV. The Illinois insurance law does not substantively conflict with ERISA. Rush fails to meet its burden of showing conflict and fails to overcome the strong presumption that Congress did not intend to supersede state health and insurance regulation.

ERISA, on its face, permits plan sponsors, insurers selling insurance to ERISA plans and sponsors, and States to supplement the minimum requirements for claims procedures established by ERISA. Moreover, the Department of Labor's implementing regulations (authorized by ERISA) confirm that ERISA's claims procedures set minimums and that they may be supplemented by state insurance regulation, including, specifically, state external review procedures.

As contemplated by ERISA, a beneficiary may prevail on her claim for benefits under independent review or at any other stage of an administrative claims procedure. If the beneficiary does prevail at any stage, the administrative process is then complete. At the same time, nothing in Illinois law precludes further action under ERISA's enforcement scheme if the claim is denied under independent review. It does not conflict with ERISA.

Consistent with this Court's decisions, the Illinois law can be enforced as a mandated contract term through ERISA's civil enforcement provision. The Illinois law does not put

Illinois HMO insurers in the position of choosing whether to follow their obligations under state or federal law; they are obligated to comply with both. Thus, the Illinois law is not preempted because it operates as a state insurance law in conjunction with — not in opposition to — ERISA's civil enforcement scheme. In *UNUM*, this Court rejected an ERISA insurer's argument that its policy language displaced state insurance regulation, saying the argument made "scant sense," because it would render States powerless to regulate insurance companies that sell insurance to or for ERISA plans. The insurer could displace State regulations simply by inserting a contrary term in the insurance contract, thereby writing the saving clause out of ERISA.

V. Even if the Illinois law were not enforceable under the ERISA enforcement statute, that would not mean it is not enforceable at all. Rather, if the Illinois statute cannot be enforced through ERISA, it is enforceable under state law. ERISA does not preempt state law claims based on wrongs for which it provides no remedy.

VI. Independent of ERISA's saving clause for state laws that regulate insurance, the Illinois law applies in this case because, by its express terms, Rush's insurance policy voluntarily incorporates it as a term of the insurance coverage. The meaning of the terms of written documents is a matter of the parties' intent. As the HMO policy expressly incorporates state law governing HMO insurance policies, the Illinois independent review provision applies by force of the terms of the HMO policy itself.

VII. If the Court reversed the court of appeals' decision finding no preemption, then Moran's appeal on her breach of fiduciary duty claim must be decided because the Seventh Circuit did not reach that issue. The record demonstrates a question of fact which requires remand to determine the breach of fiduciary duty claim.

ARGUMENT

I. Introduction

The essence of the HMO's promise to insurance consumers who choose its product (including employers and their employees) is that, except for certain specified exclusions, the HMO will cover all treatment that is "medically necessary." Only when the insured becomes a patient does she have occasion to ask what is "medically necessary." It is reasonable for the insured to believe, as Debra Moran believed, that "medical necessity" is decided on an objective basis. In the vast majority of cases, the primary physician and the HMO's insurance administrator agree on medical necessity. Only when, as here, they disagree, does Illinois require an objective, independent third-party review to remove the HMO's inherent financial motive to deny care, and thus protect both the well-being of the insured patient and the integrity of the medical decision-making process.

This case capsulizes the controversy in managed health care about the need for independent review of insurance determinations regarding patient treatment. Rush's "medical necessity" insurance decision here resulted from self-interest and illustrates the danger in having such a determination made by a company standing to gain by it: the arbitrary denial of appropriate, needed medical care. Fortunately, Debra Moran was able to borrow from her future to obtain the needed treatment and avert catastrophe. Unfortunately, Rush refused to abide by Illinois law to provide Debra Moran the insurance coverage to which she was entitled. Rush put its financial interests ahead of Moran's need to retain the use of her arm. Illinois requires an independent determination under these circumstances. Rush agreed to provide it. Federal law does not interfere with this traditional state health and insurance regulation.

Rush does not attack the process of independent review *per se*, but says ERISA precludes the States from requiring it. Rush's own amicus has urged the HMO industry to provide independent review; industry leaders have agreed to give it; and, as noted by the National Association of Insurance Commissioners ("NAIC"), independent review "is heralded as being a fair, impartial and usually expeditious way to resolve disputes." NAIC Brief in Support of Certiorari, p. 7. State independent review laws are intended to improve the quality of care provided and consumer insureds benefit from the availability of an independent, unbiased review of a health insurer's decision.

One basic premise underlies all the briefs filed in support of Debra Moran: she should be able to enforce the Illinois independent review law and obtain recovery for the costs she incurred. Her attempt to do so was cut short by a now-common HMO insurer tactic — removal to federal court and assertion of ERISA preemption. The Court can and should put an end to such tactics. The Court should hold that ERISA does not preempt Section 4-10 because it does not "relate to" ERISA-covered benefit plans and because, in any event, it is a state law that regulates insurance (and not the plan that purchases it).

Rush has the heavy burden of establishing that a state law which on its face regulates insurance is nevertheless preempted, despite ERISA's saving clause. Instead of carrying that burden, Rush and its amicus decry the administrative burdens they claim independent review would impose. But, as this Court has repeatedly held, the cost of state insurance regulation is irrelevant in view of the saving clause. In any event, Rush provided *no evidence* below about "administrative" burdens of independent review, and there is no evidence before the Court to show independent review

would unduly increase HMO costs in Illinois.[6] Rush's real goal is to maintain exclusive control of the determination of "medical necessity," by denying to the State of Illinois its historic right to regulate the activities of insurers and protect consumers from unreasonable denials of coverage.

This Court has long noted the "continuing necessity in our Federal system for accommodating the two great powers it comprehends" — that is, "the paramount national authority over commerce" and "the states' reserved powers touching the same or related subject matter." *Prudential Ins. Co. v. Benjamin*, 328 U.S. 408, 412-13 (1946). This case is another in the long line of cases addressing that dichotomy. The specific issue here is whether the Illinois legislature can regulate HMO insurers operating in Illinois when they insure ERISA plan benefits, by requiring independent review of disputed medical necessity decisions. Debra Moran says "yes," because nothing in ERISA requires that "medical necessity" decisions must be finally made by an HMO insurer for health insurance sold to an ERISA benefit plan. Rather, ERISA specifically permits such traditional state regulation of insurance through the saving clause. 29 U.S.C. § 1144(b)(2)(A).

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6. According to a 1998 report by the General Accounting Office, an industry review reported that "external review would cost no more than $.07 per enrollee per month. . . . [T]he estimated cost is small because, in practice, only a small number of appeals reach the external review process. Once the cost is divided among the total number of enrollees, the cost per enroliee is very low." *United States General Accounting Office*, HMO Complaints and Appeals, GAO/HEHS-98-119 (May 12, 1998). Furthermore, according to Rush's amicus, American Association of Health Plan ("AAHP"), in States that have independent review statutes and have reported data, "one appeal is filed for every 14,000 enrollees." AAHP, "Independent Medical Review of Health Plan Coverage Decisions: Empowering Consumers With Solutions" (April, 2001), available on line at www.aahp.org.

Rush chose to operate as an insurer in Illinois knowing about the Illinois HMO Act and Section 4-10 in particular. Rush also specifically provided coverage for "medically necessary" services, with knowledge that Illinois law required independent review of medical necessity decisions, but Rush gave no notice to employers purchasing its insurance or their covered employees that Rush would not follow that law. To the contrary, Rush expressly incorporated Illinois law as part of the policy. Moreover, the statute applies to all HMO insurance, and thereby to anyone who purchases that insurance, whether they are part of an ERISA plan or not. Rush is trying to avoid its legal obligation under state insurance law simply because it contracted with an ERISA plan. That is not ERISA's intent.

II. The Illinois Independent Review Law Is Not Preempted By ERISA Because It Does Not "Relate To" ERISA-Covered Benefit Plans.

A. Rush and its contract for HMO insurance are not the employee benefit plan governed by ERISA.

Rush never makes clear the fundamental difference between: (1) Rush (the HMO) and its contract to provide HMO insurance; and (2) the employee benefit plan established by Ms. Moran's spouse's employer and governed by ERISA. Rather, Rush and its amicus try mightily to confuse and obscure this basic distinction by implicitly equating the HMO and its services with the ERISA plan. *See, e.g.*, Pet. Br. 4, 8, 17; Amicus Br. 2, 4 n.2, 26. Rush even refers to (and quotes) its HMO member's "Certificate" as the "ERISA plan." Pet. Br. 13.[7]

7. Rush quotes the dissenting opinion's argument that:

> If the statute merely regulates insurance and therefore is not preempted, how can it be part of an ERISA plan and enforceable in federal court? If, on the other hand, the requirement imposed by the [Illinois] statute is and must

(Cont'd)

In fact, Rush, the party which bears the burden of proof on its affirmative defense of preemption, R.1, Answer, p.3, presented *no evidence* that it, its HMO insurance contract or services, or its Member Certificate, is an ERISA benefit plan. Furthermore, Rush and its insurance contract plainly are *not* the ERISA plan.

Rush's Member Certificate says it together with "the Group Contract" are a contract between Rush and "the Employer." R.38, Ex. A, p.7. The Certificate expressly distinguishes the "Group Contract" (and HMO "Coverage" under that Contract) from the "Employer's Health Benefit Plan." R.38, Ex. A, p. 8. (definitions); R. 38, Ex. A, p. 10 (employee may elect between Rush HMO coverage and other health care coverage provided by the employer's benefit plan). Furthermore, the Certificate lacks basic requirements for an ERISA plan[8] and summary plan description.[9]

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> be incorporated into the plan, then Illinois has done more than merely regulate the contents of an insurance policy.

Pet. Br. 16. This argument also misunderstands the difference between the HMO insurance policy (which Rush sells) and the ERISA plan established by the employer. The Illinois statute is not "incorporated into the plan." Rather, it is "incorporated into" the insurance policy that the plan or plan sponsor purchased. The HMO insurance policy is "enforceable in federal court" because it is the funding vehicle for delivering the benefits promised by the ERISA plan and 29 U.S.C. § 1132(a) provides plan participants and beneficiaries with causes of action to recover benefits due under the plan and to enforce the terms of the plan. The statute does not limit the potential defendants in such suits to plans and plan sponsors.

8. For example, every ERISA plan must "provide a procedure for amending such plan. . . ." 29 U.S.C. § 1102(b)(3).

9. For example, a summary plan description must contain "the employer identification number (EIN)," 29 C.F.R. § 2520.102-3(c);

(Cont'd)

Two related points ignored by Rush are also highly significant to the ERISA preemption issue. First, the Illinois HMO statute, including Section 4-10, applies to *all* HMO insurance and consumers, not merely to the insurance provided to ERISA plans and their beneficiaries. The Illinois statute applies equally to HMO insurance provided to employee benefit plans not covered by ERISA (*e.g.* church plans, government plans) and under contracts with individual persons.

Second, ERISA-covered benefit plans have alternatives to HMOs in providing health and medical benefits. Information provided by Rush indicates that 40% of the coverage provided by ERISA plans is done through self-insurance. Pet. Br. 27 n.7. Traditional fee-for-service insurance, PPOs and other non-HMO alternatives are also available, none of which are subject to the Illinois independent review statute for HMOs.

B. Under this Court's general preemption analysis, the Illinois law does not "refer to" or have a "significant connection with" ERISA plans.

ERISA provides that it "shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). In its recent preemption decisions, the Court's analysis has started with the presumption "that the historic police powers of the states

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the "name of the person designated as agent for service of legal process, and the address at which process may be served on such person," *id.* § 2520.102-3(f); and the "statement of ERISA rights authorized by section 104(c) of the Act", *id.* § 2520.102-3(t)(1). In fact, of 16 applicable requirements for an ERISA summary plan description under the governing regulation, Rush's Member Certificates lacks at least nine. *Compare* 29 C.F.R. § 2520.102-3 *with* R.38, Ex. A, pp. 1-41 and exhibits.

were not to be superseded by the federal act unless that was the clear and manifest purpose of Congress." *New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 653-655 (1995). Following *Travelers*, the Court in *California Div. of Labor Standards Enforcement v. Dillingham Constr. Co.*, 519 U.S. 316 (1997), held that there must be a clear indication in ERISA or its legislative history of an intent on the part of Congress to preempt a law in a traditionally state-regulated area. 519 U.S. 331-32.

A state law only "relates to" an ERISA plan if it refers to or has significant connection with an ERISA plan. A law "refers to" an ERISA plan when a "state's law acts immediately and exclusively upon ERISA plans . . . or where the existence of ERISA plans is essential to the law's operation." *Dillingham*, 519 U.S. at 325. In order to determine whether the law has a significant connection to an ERISA plan, a court must examine ERISA's objectives to determine the type of state laws Congress would not have intended to preempt and the effect the state law has on ERISA plans. *Id.* If the state law merely "alters the incentives" for an ERISA plan, "but does not dictate the choices," then the law is not sufficiently connected with an ERISA plan to require preemption. *Id.* at 334. The Court made clear that ERISA preemption does not encompass state regulation of health care merely because it has an economic effect on an ERISA plan:

> If ERISA were concerned with any state action — such as medical care quality standards or hospital workplace regulations — that increased costs of providing certain benefits, and thereby potentially affected the choices made by ERISA plans, we could scarcely see the end of ERISA's preemptive reach.

Dillingham, 519 U.S. at 329.

In *DeBuono v. NYSA-ILA Medical and Clinical Services Fund*, 520 U.S. 806 (1997), the Court emphasized its view of the scope of ERISA preemption, noting that the Second Circuit had failed to "give proper weight to *Travelers'* rejection of a strictly literal reading of [the preemption clause]." 520 U.S. at 812-13. *DeBuono* underscored that the "historic police powers of the state include the regulation of matters of health and safety" over which the Court presumed there would be no federal preemption. *Id.* at 813.

Travelers, *Dillingham* and *DeBuono* stress that there is a heavy presumption against preemption of state laws regulating health and safety. Because the Illinois independent review law operates in two areas of traditional state regulation — health care and insurance — the Court should presume that Congress did not intend for ERISA to supplant that law. Moreover, the Illinois independent review law neither refers to nor has a significant connection with ERISA plans because the law applies *only* to HMO insurers, not ERISA plans. Therefore, applying the Court's general preemption analysis, the Illinois law is not preempted by ERISA.

Employers may or may not elect to purchase the insurance coverage provided by Illinois HMOs in order to pay for health benefits for their employees through their employee welfare benefit plans. The Illinois independent review law regulates the provision of HMO insurance and not ERISA plans. The law's requirements fall on insurers to provide independent review and insurance coverage in the event medical necessity is found, and "do not have anything to do with employee benefit plans in particular." *See Washington Physician Serv. Ass'n v. Gregoire*, 147 F.3d 1039, 1044-45 (9th Cir. 1998), *cert. denied*, 525 U.S. 1141 (1999) (the fact that state's alternative provider statute regulates a product that ERISA plans often choose to buy by requiring HMOs to cover alternative medical treatments such

as acupuncture does not mean that it "relates to" an ERISA plan; "the [state statute] does not require employers to provide any particular welfare benefit to employees, and it does not impose any burden on the plan in administering any benefits it chooses to provide. All of these burdens fall on the health carrier.")

Nor does the independent review law have a "significant connection with" the administration of employee benefits, such as to require ERISA preemption. It has no such connection because it does not dictate the choices an ERISA plan may make. Preemption does not occur if the state law has only a remote or peripheral connection with covered plans, as in the case with many laws of general applicability. *Travelers*, 514 U.S. at 661 (citations omitted). For example, state licensing of doctors within an HMO imposes certain indirect limitations on ERISA plans. As a consequence of such state regulations, ERISA plans cannot legally purchase HMO services that provide unlicensed health care treatment. Similarly, such state laws may restrict the activities of physicians who may practice with HMOs under state registration and regulatory requirements. But those restrictions do not bind the ERISA plan — they bind doctors and the HMOs who employ them. *See State Bd. of Registration For The Healing Arts v. Fallon*, 412 S.W.3d 474 (Mo. 2001), *cert. denied*, 2001 U.S. LEXIS 9987, 70 U.S.L.W. 3315 (October 29, 2001) (state administrative physician registration and review requirements not preempted by ERISA). So it is with the Illinois independent review law. If the law is followed, the independent reviewer's determination as to medical necessity is binding on the insuring entity, the HMO, but the statute does not compel an ERISA plan to do anything. Rather, once independent review determines a procedure is "medically necessary," that procedure becomes one for which a state can require the HMO insurer to pay under state health and insurance law.

III. The Independent Review Law Regulates Insurance and Is Saved From Preemption In Any Event.

In *UNUM*, the Court reaffirmed the analysis used to resolve whether a state law "regulates insurance" within the meaning of the saving clause. First, it determines whether, from a common-sense view of the matter, the contested law regulates insurance. Second, it considers the three factors employed to determine whether the regulation fits within the "business of insurance" as that phrase is used in the McCarran-Ferguson Act: (1) whether the practice transfers or spreads risk; (2) whether it is an integral part of the insurer-insured understanding; and (3) whether the practice is limited to entities within the insurance industry. *UNUM*, 526 U.S. at 367-68. As was true of the state law in *UNUM*, the Illinois law regulates insurance as a matter of common sense and meets at least two of the three McCarran-Ferguson factors. Therefore, it regulates insurance under the saving clause.

A. The independent review law is a state insurance law.

1. The Illinois law regulates insurance as a matter of common sense.

The Illinois law "regulates insurance" as a matter of common sense. It controls the terms of the insurance relationship by requiring the insurer to provide independent review when there is a medical necessity dispute. The law, by its very terms, is directed specifically at the insurance industry and is applicable only to HMO insurance contracts. The rule is a regulation that hones in on the insurance industry and does not just have an impact on that industry (*UNUM*, 526 U.S. at 368), "because the law is directed at the HMO industry as insurers." Pet. App. 17a.[10]

10. This Court has stated that it does not "normally disturb an appeals court's judgment on an issue so heavily dependent on analysis of state law." *UNUM*, 526 U.S. at 367 (citing *Runyon v. McCrary*, (Cont'd)

The Seventh Circuit's decision on this point squares with other decisions by that court and the Illinois Supreme Court which make clear that HMOs are insurers under Illinois law. *See Anderson v. Humana, Inc.*, 24 F.3d 889, 892 (7th Cir. 1994) ("because HMOs spread risk — both across patients and over time for any given person — they are insurance vehicles under Illinois law"); *In re Medcare HMO*, 998 F.2d 436, 444-46 (7th Cir. 1993) (HMOs are "substantial equivalents" of insurance companies); *Petrovich v. SHARE Health Plan of Illinois, Inc.*, 188 Ill. 2d 17, 719 N.E.2d 756, 763 (Ill. 1999) (Illinois Supreme Court describes HMOs and other managed care organizations as having "stepped into the insurers' shoes").[11]

(Cont'd)

427 U.S. 160, 181-182 (1976)). Amicus claims that this principle "applies only where the 'district court and court of appeals have concurred' on the state law's meaning, which is not the case here." Amicus Br. at 26 n.12. As *UNUM* itself demonstrates, that is simply not the case. In *UNUM*, this Court left undisturbed the Ninth Circuit's interpretation of California's notice-prejudice rule despite the fact that the appellate court reversed the district court's grant of summary judgment in favor of *UNUM*. The district court had held that the rule did not regulate the business of insurance and was therefore preempted. *Ward v. Mgmt. Analysis Co.*, No. CV-1454H (AJB) 1995 U.S. Dist. LEXIS 21995 (S.D. Cal., August 8, 1995).

11. That conclusion is buttressed by the numerous decisions by other courts holding that HMOs are insurers. *Gregoire*, 147 F.3d at 1045-46 ("The only distinction between an HMO (or HCSC) and a traditional insurer is that the HMO provides medical services directly, while a traditional insurer does so indirectly by paying for the service, but this is a distinction without a difference. In the end, HMOs function the same way as a traditional health insurer. The policyholder pays a fee for a promise of medical services in the event that he should need them. It follows that HMOs (and HCSCs) are in the business of insurance.") (internal citation omitted); *see also Express Scripts, Inc. v. Wenzel*, 262 F.3d 829, 835 (8th Cir. 2001); (Cont'd)

In *Pegram v. Herdrich*, 530 U.S. 211(2000), this Court described the evolution from traditional fee for service insurance to HMOs, and recognized that HMOs are risk-bearing organizations that function much like traditional insurers. Therefore, a law that "regulates HMOs" regulates insurance from a common sense perspective. The Seventh Circuit also ruled that the HMO Act regulates insurance under a common sense understanding because the Act goes to the core of the relationship between the insurer and the insured. This is because insurance law provides that valid statutory provisions become part of all contracts of insurance to which they are applicable as if actually incorporated therein. Pet. App. 17a.

(Cont'd)

Kentucky Ass'n of Health Plans, Inc. v. Nichols, 227 F.3d 352, 364-65 (6th Cir. 2000), *petition for cert. filed*, 69 U.S.L.W. 3646 (U.S. March 22, 2001) (No. 00-1471); *Corporate Health Ins. Inc. v. Texas Dep't. of Ins.*, 215 F.3d 526, 538 (5th Cir. 2000), *further opinion* on *petition for reh'g*, 220 F.3d 641 (5th Cir., 2001), *petition for cert. filed, sub nom., Montemayor v. Corporate Health Ins., Inc.* 69 U.S.L.W. 3317 (U.S. Oct. 24, 2000) (No. 00-665); *Garofalo v. Empire Blue Cross and Blue Shield*, 67 F. Supp. 2d 343, 352 (S.D.N.Y. 1999) (statute saved as applied to HMOs to the extent they acted as insurers); *American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc.*, 973 F. Supp. 50 (D. Mass. 1997); *Cellilli v. Cellilli*, 939 F. Supp. 72 (D. Mass. 1996); *In re Beacon Health, Inc.*, 105 B.R. 178, 186-187 (Bankr. D.N.H. 1989) ("The HMO is simply an insurance company covering its obligation to protect subscribers against medical care charges in excess of the premium collected from them by providing the services directly in kind, or indirectly through contract physicians, rather than after-the-fact reimbursing in cash for charges paid directly by the subscriber elsewhere."); *Health Plan v. Citizens Ins. Co.*, 673 F. Supp. 903 (W.D. Mich. 1987); *cf. Stuart Circle Hosp. Corp. v. Aetna Health Mgmt.*, 995 F.2d 500, 504 (4th Cir. 1993) (holding that law regulating PPOs regulated insurance).

The conclusion that an HMO is an "insurer" and therefore that Section 4-10 "regulates insurance" within the meaning of ERISA's saving clause is reinforced by other federal laws addressing HMOs. For example, the Health Maintenance Organization Act of 1973, Public Law 93-222, 42 U.S.C. § 300e ("HMO Act"), enacted on December 29, 1973 by the same Congress which enacted ERISA, provided for the formation of federally qualified HMOs. Two facets of the HMO Act support Moran's position.

First, according to the HMO Act, federally qualified HMOs are obligated to assume financial risks for the provision of health care services to their members. *See* 42 U.S.C. § 300e. In return for a fixed, prepaid, and uniform payment, an enrollee in an HMO shifts the risk of at least the cost of his or her basic health services to the HMO. That risk is spread throughout the HMO via a "community rating system." Except for certain enumerated exceptions, "an HMO is required to assume the full financial risk of providing basic health services to its members, on a prospective basis, without the benefit of reinsurance." *See* Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, S. Rpt. No. 14, at 4 (Feb. 1974) ("HMO Act Conference Report"); 42 U.S.C. § 300e(c)(2).

Second, the HMO Act, as enacted in 1973, was specific about the "restrictive provisions" of state laws which it preempted. These laws were specifically delimited and included laws which "[directed] the HMO to meet requirements as an insurer of health care services in that state regarding initial capitalization and the establishment of financial reserves." HMO Act Conference Report at 12. Had Congress intended to preempt a State's ability to "direct the HMO to meet requirements as an insurer of health care services" in every respect, not simply with regard to its initial capitalization and the establishment of financial reserves, it

would have been easy to say so. The fact that Congress specifically identified the areas in which contrary state law would be preempted reinforces the notion (supported further by the McCarran-Ferguson Act) that, apart from these areas, States remained free to include HMOs in their traditional regulation of insurers.

2. The Illinois law meets the McCarran-Ferguson factors.

The Seventh Circuit ruled, in accordance with *UNUM*, 526 U.S. at 375 n.5, that "when a law mandates a contract term between parties, whether that term is characterized as creating a procedural or substantive right, that law is integral to the insurer/insured relationship." Pet. App.17a-18a. Thus, the law meets at least two of the McCarran-Ferguson factors because: (1) it is an integral part of the policy relationship; and (2) it is limited to entities within the insurance industry. While the third factor — the transfer or spread of risk — is not required under *UNUM* (526 U.S. 373) to determine the Illinois law "regulates insurance," the law also satisfies that factor.

The independent review law does operate in individual circumstances, as with any insurance coverage determination. If coverage is found under this law, however, it operates to transfer or spread risk to all policyholders. In this respect, it acts on an individual basis just like the state notice-prejudice rule this Court concluded was not preempted in *UNUM*. The position of the United States as amicus in *UNUM* was that the notice-prejudice rule operated to spread risk. 526 U.S. at 374. *See also United States Dep't of Treasury v. Fabe*, 508 U.S. 491, 503-504 (1993) (in holding that the actual performance of a contract constitutes the "business of insurance" within the meaning of the McCarran-Ferguson Act, the Court notes that "without performance of the terms of the insurance policy, there is no risk transfer at all.")

In the ERISA context, there is no difference between HMOs and traditional insurers regarding the risk insured in relation to the plan. From the perspective of a plan, both an HMO and a traditional insurer are available to "insure" its risks. In either case, the plan or plan sponsor contracts with the provider for certain agreed-upon healthcare coverage for the plan participants and beneficiaries in exchange for a negotiated price. If the demand for medical services exceeds expectations, the realized loss is borne by the provider, whether an HMO or traditional insurer. Likewise, the risk that one or more participants or beneficiaries will incur extraordinary costs is spread among the entire group covered under the plan.

Rush and its amicus devote substantial space in their briefs to arguing that, because Section 4-10 appears to encompass HMOs that perform only administrative services for self-funded plans, the law is not limited to entities within the insurance industry and must be preempted. This argument proves too much and too little.

It proves too much because the Court has had no trouble finding, in similar situations, that the statute at issue was not preempted. For example, in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), Massachusetts enacted a mandated-benefits statute which required certain mental health benefits to be provided by every general health-insurance policy or every benefit plan which provided hospital and surgical coverage. 471 U.S. at 729-30 n.11. On its face, the statute applied directly to benefit plans — entities obviously outside the insurance industry and protected from state insurance regulation by ERISA's "deemer" clause. The Court did not hold that the statute was preempted because it could apply directly to a plan. To the contrary, the Court held that, when applied to health insurers, the statute was saved from preemption. 471 U.S. at 758.

Similarly, the Court in *Sec. and Exchange Comm'n v. Nat'l Sec. Inc.*, 393 U.S. 453 (1969), determined that an Arizona law authorizing a state official to approve mergers of insurance companies was a law regulating the business of insurance to the extent the official acted to ensure that the merger did not "substantially reduce the security of and service to be rendered to policyholders," 393 U.S. at 462, but not when the official acted to ensure that the merger was not "inequitable to the stockholders of any insurer," *Id.* at 457.

The contention also proves too little because, even assuming that Section 4-10 would raise preemption questions if applied to an HMO which provided only administrative services for self-insured plans, that simply is not the case here. It is undisputed that the plan at issue is fully insured. As such, the "administrative-services-only" argument is a straw man that has no bearing on the case before the Court.

B. The Illinois law regulates the insurer, not the plan.

This case falls squarely within the Court's decisions in *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), finding that a state may indirectly regulate ERISA plans by direct regulation of their insurers, and *Metropolitan Life*, 471 U.S. 724 (1985), finding exempt from ERISA preemption a mandated-benefit law requiring insurance companies to provide minimum mental health benefits. The only difference here is that "medical necessity" (and hence insurance coverage) is determined on a case-by-case basis, rather than across the board as in *Metropolitan Life*.[12]

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12. Indeed, viewed in this context, Section 4-10 is less intrusive on insurers than the mandated-benefit laws already found not preempted by this Court.

Rush claims the Illinois law changes the employer's ERISA *plan* and therefore is preempted. Pet. Br. 19. This is simply not so. Illinois law requires that an HMO insurer provide independent review via Section 4-10. If an ERISA plan purchases HMO insurance coverage in Illinois, that coverage will have, as a contract term, independent review as set forth in Section 4-10. Nothing in this scheme offends ERISA because, just like the minimum health care benefits requirements under the Massachusetts law reviewed in *Metropolitan Life*, 471 U.S. 724, and just like the notice-prejudice rule reviewed by this court in *UNUM*, 526 U.S. 358, Illinois requires insurers to provide independent review in HMO insurance policies in Illinois.

ERISA plans and plan sponsors are free to purchase or not purchase such insurance. They may self-insure. They may provide traditional, fee-for-service insurance coverage. They may provide PPO coverage. In the event they choose HMO coverage in Illinois, that coverage and that insurance contract will include an independent review provision as required by Section 4-10. The plan does not change. The plan uses an insurance product as the funding vehicle to provide plan benefits. If that insurance product is an HMO insurance plan, it will include an independent review provision. This is classic state regulation of insurance specifically exempted from ERISA preemption by Congress. This insurance law is not preempted.

C. This Court has rejected Rush's "administration," "cost" and "uniformity" arguments.

Rush repeatedly argues that Section 4-10 relates to the "administration" and affects the "uniformity" of ERISA plan benefits, and therefore should be preempted because it is inconsistent with "core" ERISA concerns. Pet. Br. 20, 25. These arguments were rejected by this Court in *UNUM*:

> We reject UNUM's suggestion that because the notice-prejudice rule regulates only the

> administration of insurance policies, not their substantive terms, it cannot be an integral part of the policy relationship. *See*, *Metropolitan Life*, 471 U.S. at 728 n.2 (including laws regulating claims practices and requiring grace periods in catalogs of state laws that regulate insurance).

UNUM, 526 U.S. at 375 n.5. The Court also stated:

> The notice-prejudice rule serves as an "integral part of the policy relationship between the insurer and the insured." *See Metropolitan Life*, 471 U.S. at 743. California's rule changes the bargain between insurer and insured; it "effectively creates a mandatory contract term" that requires the insured to prove prejudice before enforcing a time limits of claim provision.

UNUM, 526 U.S. at 374; *see also Metropolitan Life*, 471 U.S. at 747 ("we also are aware that applicants' construction of the statute would eliminate some of the disuniformities currently facing national plans that entered into local markets to purchase insurance. Such disuniformities, however, are the inevitable result of the congressional decision to 'save' local insurance regulations. Arguments as to the wisdom of these policy choices must be directed at Congress."). As in *UNUM*, the Illinois HMO Act also "effectively creates a mandatory contract term" that requires the insurer to provide independent review of the disputed medical necessity decision. *UNUM*, 526 U.S. at 374; *Plumb v. Fuller Pump Serv.*, 124 F.3d 849, 859 (7th Cir. 1997). Rush ignores this rule of law in its brief. Analytically, there is no reasonable distinction to be made among a state mandatory-insurance benefit law, an anti-subrogation rule and a notice-prejudice requirement (each of which this Court has found not

preempted) and the independent review requirement here.[13] Each kind of mandate must be viewed as a matter of state insurance law which has been incorporated into the terms of the insurance purchased by plans in that state; none of these state mandates "conflict[s] with a substantive provision of ERISA." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 57 (1987).

The cases where the Court has upheld the "administration" argument do not support Rush because they involved direct ERISA plan regulation. *Fort Halifax Packing Co. v. Coyne*, 428 U.S. 1 (1987), for example, makes the distinction between burdens imposed on plans versus administrative burdens on plan benefits. 482 U.S. at 911 ("Congress preempted state laws relating to plans, rather than simply to benefits . . . the Maine statute neither establishes nor requires an employer to maintain an employee benefit plan."); *see also FMC Corp.*, 498 U.S. at 52, 60 (Pennsylvania anti-subrogation statute preempted because it acted directly on ERISA plans; indirect regulation of plan by regulation of its insurer permissible).

Rush and its amicus advance policy arguments based on cost and uniformity so that insurance costs (and apparently thereby employer costs via the purchase of such insurance) are controlled. Rush relies on the dissent on denial of rehearing in *Moran* to support this assertion "[that] the Illinois law will shrink benefits and deter some employees from offering health insurance at all." Pet Br. 30. This Court has repeatedly said a "cost" effect on an insurer will not defeat the operation of the saving clause. *Travelers*, 514 U.S. at 657 ("an indirect economic influence, however, does not bind

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13. In *UNUM*, the Court found that the state notice-prejudice rule did not conflict with ERISA § 503's notice and claim review requirement because "by allowing a longer period to file than the *minimum* filing terms mandated by federal law, the notice-prejudice rule complements rather than contradicts ERISA and the regulations." 526 U.S. at 377 (emphasis original).

plan administrators and thus function as a regulation of ERISA plan itself."); *DeBuono*, 520 U.S. at 816 ("any state [law] . . . that increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is preempted by the federal statute."). Thus, this cost argument is baseless because cost is irrelevant to determining whether a law regulates insurance with the meaning of ERISA's saving clause. For example, mandated benefit laws add costs to the plans that choose to purchase insurance rather than self-insure, but that fact did not prevent this Court from deciding in *Metropolitan Life* that the Massachusetts mental health law regulated insurance within the meaning of the saving clause. Similarly, procedural protections like the notice-prejudice rule at issue in *UNUM* add costs by causing claims to be paid that would otherwise be denied. A law mandating independent review is no different.

Rush's cost argument is also premised on the fallacy that only insurance companies incur costs and expenses in providing employee benefits such as health insurance. That is not true; both employers and insured employees incur costs. Specifically, an employee contracts with an employer to exchange her labor for salary and benefits. The employees earn the benefits for which they have contracted and often pay a part of the premium. Rush and its amicus cannot take those earned benefits away by arguing a "policy" that they do so to reduce costs. Debra Moran and her husband earned coverage for necessary medical procedures. If that means that Rush incurs increased costs because it must provide independent review about medical necessity, that was part of the bargain Rush made, and it was part of the benefit Paul and Debra Moran earned. ERISA was never meant to take that away.

Rush's uniformity argument similarly fails because this Court has repeatedly held the absence of uniformity is a necessary consequence of ERISA's saving clause and, therefore, will not defeat its enforcement:

> As we have pointed out . . . the saving clause retains the independent effect of protecting state insurance regulation of insurance contracts purchased by employee benefit plans. . . . Our interpretation of the deemer clause makes clear that if a plan is insured, a state may regulate it indirectly through regulation of its insurer and its insurer's insurance contract; if the plan is uninsured, the state may not regulate it. As a result, employers will not face "conflicting or inconsistent state and local regulation of employee benefit plans."

FMC Corp., 498 U.S. at 64; *see also UNUM*, 526 U.S. at 376 n.6 ("we recognize that applying the States' varying insurance regulations creates disuniformities for 'national plans that enter into local markets to purchase insurance.' *Metropolitan Life*, 471 U.S. at 747. As we have observed, however, 'such disuniformities . . . are the inevitable result of the Congressional decision' to save local insurance regulation.' *Ibid.*")

Rush closes its brief with its cost argument, complaining of "[c]hanges in the industry," "[p]oorly drafted laws" and "a blurring of pertinent distinctions in . . . health insurance," Pet. Br. 43, and implicitly inviting the Court to rewrite the law so as to conform to Rush's view of wise healthcare policy. The invitation should be declined.

First, it is historically inaccurate to imply that industry "changes" have created circumstances the Congress that enacted ERISA could not have foreseen (*i.e.*, HMOs rather than traditional fee-for-service health insurance). The Federal HMO Act was passed in 1973, a year before ERISA. 42 U.S.C. § 300e.

Thus, Congress certainly knew about HMO insurers when it passed ERISA. Had it wanted to exclude from the "expansive" scope of ERISA's saving clause remedial legislation regulating HMOs under state insurance laws, it could easily have done so.

Second, Rush's view of wise policy is not even shared by other members of its industry. One of its supporting amicus, AAHP, has published multiple reports this year extolling independent medical reviews as "successful" and "empowering consumers with solutions." *See* AAHP, "Independent Medical Review of Health Plan Coverage Decisions: Empowering Consumers with Solutions," (April, 2001); and AAHP Report, "Health Plan Liability: What You Need to Know" at 11-12 (March, 2001).[14]

Third, even where a changing industry has created difficulties not foreseen by Congress, the appropriate response is not for courts to recast the substance of a statute in the guise of interpreting it. This Court so held in a case that did involve a fundamentally changed industry — specifically, a growing number of so-called "nonbank banks" being set up outside the control of the Federal Reserve Board. *Board of Governors v. Dimension Fin. Corp.*, 474 U.S. 361 (1986). Holding that the administrative agency had no authority outside the scope of the existing legislation to regulate these new entities, the Court explained:

> If the Bank Holding Company Act falls short of providing safeguards desirable or necessary to protect the public interest, that is a problem for Congress, and not the Board or the courts, to address.

Id. at 374.

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14. Both publications are available online at www.aahp.org.

IV. The Illinois Law Does Not Conflict With ERISA.

Rush argues that if the Illinois law is saved by the saving clause from ERISA it is still preempted because it somehow violates ERISA and its enforcement scheme. Pet. Br. 19. This argument fails because the Illinois law does not conflict with 29 U.S.C. §§ 1132 or 1133.

A. ERISA permits States to complement its claims procedures.

Rush's "conflict" argument fails in the first instance because it would mean ERISA plan sponsors could not voluntarily provide for independent review, nor could insurance policies they elect to purchase. No one believes this is true.[15]

Moreover, Rush's conflict argument is directly contradicted by ERISA and its enabling regulations. 29 U.S.C. § 1022, entitled "summary plan description," sets forth the requirement that a plan provide such a description and specifies the information that shall be included. It provides in relevant part:

> (b) the summary plan description shall contain the following information:
>
> . . . .

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15. Actual practice reveals the opposite. A number of prominent national health insurers have agreed to provide independent outside review of medical necessity. *See, e.g.*, New York Times, 1/13/99, "Aetna to Allow Outside Reviews of Care Denials." (Appendix M to Moran's 7th Circuit brief); and Managed Care Reporter, July 28, 1999, "United Health Care Launches External Appeals Process For Coverage Decisions." (Appendix N to Moran's 7th Circuit brief). Indeed, Rush's own amicus in this Court, the American Association of Health Plans itself, urged the HMO industry to voluntarily let patients who are denied care appeal to outside experts. (Chicago Daily Law Bulletin, February 23, 1999, "Health Maintenance Trade Group Urges External Reviews").

> The procedures to be followed in presenting claims for benefits under the plan . . . and the remedies available under the plan for the redress of claims which are denied in whole or in part (including procedures required under § 1133 of this title).

29 U.S.C. § 1022(b). Section 1133 sets forth the "claims procedure" that a plan must provide. It is a basic maxim of statutory construction that statutes are to be read to give all of their language effect, and where two sections may conflict, they are to be read if possible to give effect to both. *Walters v. Metropolitan Educ. Enter. Inc.*, 519 U.S. 202, 209 (1997); *Bailey v. United States*, 516 U.S. 137, 145 (1995); and *In re Colonial Realty Co.*, 980 F.2d 125, 132 (2d Cir. 1992). Here, the statutes can be read to give effect to both. Section 1133 provides only the ***minimum*** requirements for plan claims procedures. Section 1022's provision that the summary plan description contain the procedures for presenting claims "including procedures required under Section 1133" means a plan may provide additional procedures to those of Section 1133. Under Rush's view, however, ERISA's enforcement mechanisms are exclusive, thereby barring Illinois from requiring insurers to provide additional claims procedures to those in Section 1133 where those insurers happen to insure an ERISA plan benefit and, consequently barring plan sponsors from providing such procedures voluntarily. That reading makes the language in § 1022 meaningless, which is contrary to law. This result is avoided if ERISA is construed to mean plan sponsors and States can add procedural requirements to ERISA's basic claims procedures, which can be enforced consistent with *Pilot Life*, under ERISA's enforcement provision, 29 U.S.C. § 1132(a).

The States' ability to supplement ERISA's claims procedures is confirmed by the applicable regulations.

29 C.F.R. § 2560.503.1, entitled "Claims Procedure," provides in relevant part:

> A. Scope and Purpose. This section sets out certain ***minimum*** requirements for employee benefit plan procedures pertaining to claims by participants and beneficiaries (claimants) for plan benefits. . . .

(emphasis added). If the requirements are only "minimums," who can expand on them and add additional complementary requirements? Certainly, the plan sponsor, either directly in the plan or by funding the plan through the purchase of an insurance policy that contains such provisions. Pursuant to the plain language of the saving clause, state regulators can too. This is confirmed by 29 C.F.R. § 2560.503.1(c), which provides in relevant part:

> C. The claims procedure for an insured welfare or pension plan. (1) to the extent that benefits under an employee benefit plan are provided or administered by an insurance company, insurance service, or other similar organization which is subject to regulation under the insurance laws of one or more states, the claims procedure pertaining to such benefits may provide for filing of a claim for benefits with a notice of decision by such company, service or organization.

Again, the language in this regulation is permissive and minimal: "may." Further, it specifically references insurance "subject to regulation under insurance law of one or more states." There would be no reason to say "may" or to reference such state regulation if it did not apply and if such insurance laws could not provide additional claims procedures. *See also* 29 C.F.R. § 2560.503-1(g) (describing review procedures, which shall "include but not be limited to" certain elements).

While Rush argues that a finding that Section 4-10 is preempted is consistent with the Department of Labor's new regulations (Pet. Br. 32 n.11), the exact opposite is true. The new regulations provide that "nothing in this section shall be construed to supersede any provision of state law that regulates insurance, except to the extent that such law prevents the application of a requirement of this section," 29 C.F.R. § 2560.503-1(K)1, and specifically provide that state external review procedures do not prevent such applications. *See* 29 C.F.R. § 2560.503-1(K)2 ("a state law regulating insurance shall not be considered to prevent the application of a requirement of this section merely because such state law establishes a review procedure to evaluate and resolve disputes involving adverse benefit determinations under group health plans so long as the review procedure is conducted by a person or entity other than the insurer, the plan, plan fiduciaries, the employer, or any employee or agent of any of the foregoing").[16]

As is always so at any stage of any claim procedure, if a beneficiary prevails under independent review, the claims process is finished and the beneficiary receives the claimed benefit. But nothing in the Illinois law precludes further action under a claims procedure (*e.g.*, appeal to a plan fiduciary) or a

16. ERISA, on its face, gives the Department of Labor authority to promulgate regulations about claims procedure. 29 U.S.C. § 1135. Even if the statute itself was not clear, these regulations confirm States can add provisions to ERISA's claims procedures, including external review. *See Bragdon v. Abbott*, 524 U.S. 624, 642 (1998) (the well-reasoned views of the agencies implementing a statute constitute a body of experienced and informed judgment to which courts and litigants may properly resort for guidance); *United States v. Mead Corp.*, 121 S. Ct. 2164, 2171, 150 L. Ed. 2d 292 (June 18, 2001) (administrative implementation of a statutory provision where that agency has authority to regulate is entitled to *Chevron* deference; considerable weight should be accorded to an executive department's construction of a statutory scheme it is entrusted to administer).

lawsuit under Section 1132 if the claim is denied under independent review.[17] The court of appeals concluded that "thus, a suit by [Moran] to enforce the HMO Act's provisions is simply a suit to enforce the terms of the plan; precisely the sort of suit that is contemplated by Section 502(a)(1)(B) 'to enforce rights' and to 'recover benefits' under the plan." Pet. App. 21a. The Seventh Circuit unanimously ruled that the HMO Act:

> requires entities in the business of insurance to provide additional safeguards to preserve the integrity of the decision making process. Following the example of the Supreme Court of the United States, we believe that such requirements ought to be treated as mandated contract terms and treated as part of the insurance contract. *See Ward*, 526 U.S. at 375-76; *see also Plumb*, 124 F.3d at 861.

Pet. App. 3a. The United States Department of Labor, the public agency responsible for interpreting and enforcing ERISA, agrees, as it asserted as amicus below that the Illinois independent review statute is not preempted, but is saved from preemption by the saving clause, and should be permitted to be enforced by ERISA. The Department of Labor argued that Section 4-10 created a mandatory contract term just like in *UNUM* that could be enforced via Section 502(a). Department of Labor, Seventh Circuit Amicus Br., pp. 8, 14, 18.[18]

17. An employee who is the beneficiary of an insured plan benefit can use Section 1132 to force the carrier to implement the administrative process such as independent review, where the carrier refuses to provide it. *E.g.*, *Flacche v. Sun Life Assurance Co.*, 958 F.2d 730, 733 (6th Cir. 1992) (§ 1132 claim may be based upon any violations of ERISA or terms of the plan).

18. Rush's argument that Section 4-10 would result in federal courts simply "rubber stamping" independent review decisions (Pet. Br. 25 n.6) is baseless, as the federal court will have the same

(Cont'd)

In *UNUM*, the Court noted that the state notice-prejudice statute before it serves to "compliment, rather than contradict ERISA and the regulations" and therefore was not preempted. 526 U.S. at 374. The Court has also noted that:

> [By] saving such insurance regulation from preemption, ERISA "leaves room for complementary or dual federal and state regulation" of the insurance industry.

John Hancock Mut. Life Ins. Co. v. Harris, 510 U.S. 86, 98 (1993). The same conclusions apply here.

B. This Court's precedents confirm the absence of conflict here.

This Court gave effect to the facially unrestricted scope of the insurance saving clause in *Metropolitan Life* when it "declined to impose any limitation on the saving clause beyond those Congress imposed in the clause itself and in the 'deemer' clause which modifies it," and concluded that "if a state law 'regulates insurance' as mandated – benefit laws do, it is not preempted." 471 U.S. at 746; *cf. Pilot Life*, 481 U.S. at 56-57 (*Metropolitan Life* clearly "rejected any interpretation of the [insurance] saving clause . . . that saved from preemption 'only state regulations unrelated to the substantive provisions of ERISA' "). In addition, the force of the saving provision's express terms is reinforced by the Court's frequent recognition — particularly in recent cases — that ERISA preemption provisions must be read against the background of the "assumption that the historic police powers of the states were not to be superseded by the Federal

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(Cont'd)
function it always had under 29 U.S.C. § 1132. These lawsuits for erroneous denial of benefits are only brought if the claim for benefits is denied. Nothing in the Illinois law alters that.

act unless that was the clear and manifest purpose of Congress." *Travelers*, 514 U.S. at 655.

The Court noted in *FMC Corp.* that the state anti-subrogation law before it "directly controls the terms of insurance contracts by invalidating any subrogation provisions that they contain," (498 U.S. 61) and cited its decision in *Pilot Life*, holding:

> [The Pennsylvania statute] does not merely have an impact on the insurance industry; it is aimed at it. *See Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 50, 95 L.Ed.2d 39, 107 S.Ct. 1549 (1987). This returns the matter of subrogation to state law. Unless the statute is excluded from the reach of the saving clause by virtue of the deemer clause, therefore it is not preempted.

498 U.S. at 61. The Court also explained the scope of *Pilot Life* in *FMC Corp.*: the Court did not distinguish between state substantive or remedial law, but rather stated categorically that if the law is aimed at the insurance industry, unless it is covered by the deemer clause, the law is not preempted. In other words, states can directly regulate ERISA plan insurers and thereby indirectly regulate an insured plan. States may not regulate uninsured plans. 498 U.S. at 64.

Moreover, the fact that federal and state laws are different does not mean that there is an impermissible conflict. ERISA is not absolute, but explicitly recognizes a role for state insurance regulation, thus permitting state insurance laws to supplement or complement ERISA's standards. *John Hancock*, 510 U.S. at 98. Illinois's independent review law provides an additional mechanism for determination of whether a particular claim is covered, thereby protecting Illinois insureds' rights. There is no conflict or inconsistency

with ERISA. Illinois law cannot be found to stand as an obstacle to the accomplishment and execution of Congressional purposes and objectives.[19]

This Court's decision in *John Hancock* illustrates the high burden that must be met in order to find that compliance with both federal and state laws is a physical impossibility. In *John Hancock*, this Court rejected the argument that ERISA and state insurance laws were at odds and "would pose irreconcilable conflicts between state and federal regulatory schemes" concerning the regulation of insurance general account contracts. 510 U.S. at 97. The Court held that ERISA's requirement that a fiduciary act solely in the interest of participants did not conflict with a state requirement that an insurer consider the interests of all its contract holders, creditors and shareholders. *Id.* at 97-98. Here too, an insurer may comply with both Illinois independent review law and ERISA's requirements for the processing of claims. The insurer can provide its own review of the claim in accordance with ERISA's minimum requirements. It can then provide independent review in accordance with Illinois law.

Illinois Section 4-10 does not put Illinois HMO insurers in the position of choosing whether to follow their obligations under state or federal law; they are obliged to comply with both. Because the operation of both provisions can be "harmonized," *John Hancock*, 510 U.S. at 98, Section 4-10 is not preempted by the traditional principles of conflict preemption. Section 4-10 operates as a state insurance law

19. In analyzing Congress' purposes, the Court looks not only at the stated purposes but at the structure of the statute as a whole. ERISA's declared principal purpose is to "protect plan participants and beneficiaries." 29 U.S.C. § 1001(b). The purpose of ERISA's claims procedure and its interpreting regulations is to provide minimum standards to protect participants and beneficiaries. 29 C.F.R. § 2560.503-1; Claims Procedure for Employee Benefit Claims, 42 Fed. Reg. 27,426 (1977).

applied in conjunction with — not in opposition to — ERISA's civil enforcement scheme.

C. Rush's argument about *Pilot Life* is contrary to *UNUM*.

Rush's application of *Pilot Life* to this case is contrary to the Court's most recent precedent on the issue in *UNUM*. This Court stated:

> UNUM and its amici assert that even if the notice-prejudice rule is saved under 29 U.S.C. § 1144(b)(2)(a), it is nonetheless preempted because it conflicts with substantive provisions of ERISA in three ways. UNUM first contends that the notice-prejudice rule, by altering the notice provisions of the insurance contract, conflicts with ERISA's requirement that plan fiduciaries act "in accordance with the documents and instruments governing the plan." § 1104(a)(1)(d). According to UNUM, § 1104(a) (1)(d) preempts any state law contrary to a written plan term.
>
> UNUM's "contra-plan term" argument overlooks controlling precedent and makes scant sense. We have repeatedly held that state laws mandating insurance contract terms are saved from preemption under § 1144(b)(2)(a). *See Metropolitan Life*, 471 U.S. at 758. ("Massachusetts' mandated benefit law is a law which regulates insurance and so is not preempted by ERISA as it applies to insurance contracts purchased for plans subject to ERISA"); *FMC Corp.*, 498 U.S. at 64 ("If a plan is insured, a state may regulate it indirectly through regulation of its insurer and its insurer's insurance contracts"). Under UNUM's interpretation of § 1104(a)(1)(d),

> however, states would be powerless to alter the terms of the insurance relationship in ERISA plans; insurers could displace any state regulation simply by asserting a contrary term in plan documents. This interpretation would virtually "write the savings clause out or ERISA." *Metropolitan Life*, 471 U.S. at 741.

UNUM, 526 U.S. at 375-76.

Rush advances the very theory rejected by this Court in *UNUM*, arguing that its policy gives it unlimited discretion to determine "medical necessity" and displaces the state regulation under Section 4-10, which requires independent review to determine medical necessity. According to this argument, Illinois is powerless to alter the terms of an insurance policy purchased by ERISA plans because Rush, as the insurer, displaced state regulation simply by inserting a contrary term in the plan documents. As the Court concluded in *UNUM*, this interpretation writes the saving clause out of ERISA and renders the Illinois legislature's efforts to regulate HMO insurance in Illinois ineffective, across the board, when purchased by or for ERISA plans. This is contrary not only to the intent of the Illinois legislation, but also to federal Congressional intent with respect to the saving clause. Rush's argument "pulls the teeth" of the Illinois independent review statute, because under its argument, while independent review can be required, it has no force or effect and can be disregarded by the HMO insurer, as it was here.

No ERISA law or regulation requires that a claims administrator for insurance purchased by a plan must have exclusive authority to apply and interpret the terms of the insurance. By virtue of the saving clause, the states are free to regulate insurance in this area by enacting review

provisions. The independent review law does just that. The Illinois statute is consistent with ERISA and complements its provisions in a Congressionally – approved form of dual regulation.

V. If For Any Reason The Requirements of Section 4-10 Are Not Enforceable Under 29 U.S.C. § 1132, Then They Are Enforceable under State Law.

As discussed above, the Illinois law is enforceable under 29 U.S.C. § 1132 just like any of the provisions of insurance policies purchased by plans or plan sponsors to provide plan benefits. Even if this were not true, however, it does not logically follow that the Illinois law is not enforceable at all. Rather, if Section 4-10 cannot be enforced under ERISA, then ERISA does not preempt and Section 4-10 is enforceable under state law. *See Benjamin*, 328 U.S. at 439 n.52 ("it would be a shocking thing, if state and federal governments acting together will prevent them from achieving the end desired by both, simply because of the division of power between them."); *Int'l Resources, Inc. v. New York Life Ins. Co.*, 950 F.2d 294, 301 (6th Cir. 1991), *cert. denied*, 504 U.S. 973 (1992) (ERISA will not preempt state law claims based on wrongs for which it provides no remedy; Kentucky conversion rights statute, which was not protected or guaranteed by an ERISA remedy, was not preempted).

Extending *Pilot Life*, as Rush suggests, to preempt the enforcement of the Illinois independent review law here would lead to "quixotic" results. In *Franklin William Ins. Trust* v. *Travelers Ins. Co.*, 50 F.3d 144, 151 (2d Cir. 1995), the Second Circuit determined that ERISA did not preempt enforcement of a New York law that regulated insurance within the meaning of ERISA. There, plaintiff moved to remand a state law cause of action for damages based on the

failure of the insurance company to comply with the state insurance law which required statutory interest on untimely payments of life insurance proceeds. The Second Circuit held that removal was improper because ERISA did not preempt the New York insurance law. It explained that "it would be quixotic to rule that a claim under a state statute that is saved from ERISA preemption . . . may nonetheless be enforced only by ERISA provisions and remedies." 50 F.3d at 151; *see also General Motors Corp. v. California State Board of Equalization*, 824 F.2d 816 (9th Cir. 1987), *cert. denied*, 485 U.S. 941 (1988) ("*Pilot Life* involves a state law of general application, one that directly conflicts with a substantive provision of ERISA. This case, in contrast, involves a state law directed specifically at the insurance industry, one that does not conflict with any of ERISA's substantive provisions.")

VI. Regardless of Preemption, Rush Voluntarily Incorporated The Illinois Independent Review Requirement Into Its Insurance Policy.

It ultimately makes no difference in this case whether the Illinois law is generally preempted or whether it is saved from preemption under ERISA's saving clause. This is because Rush's HMO insurance policy, by its express terms, voluntarily incorporates the Illinois statute as a term of the insurance coverage. Rush's Member Certificate specifically provides that:

> If the provisions of this certificate do not conform to the requirements of any state or federal law that applies to this certificate, the certificate is automatically changed to conform with the requirements of that law.

R.38, Ex. A, p. 34. Thus, Rush is obligated to provide independent medical review by the independent force of its

own insurance policy term, which "automatically change[s]" the policy to "conform with the requirements" of any state law that applies to HMO insurance coverage.

Rush buries in a footnote its only argument on this point. Pet. Br. 27-28 n.8. There, Rush advances the largely circular contention that, if ERISA preempts the Illinois statute (i.e., prevents the statute's application by force of state law), then the statute does not "apply" to the HMO policy and so (supposedly) it is not incorporated into the policy by the above-quoted provision. *Id.*, citing *Light v. Blue Cross & Blue Shield of Ala., Inc.*, 790 F.2d 1247, 1248 (5th Cir. 1986). This theory fails.

The meaning of the terms of written documents is a matter of the parties' intent. The issue in *Light* concerned an ERISA plan provision incorporating state law. 790 F.2d at 1248. Although the *Light* opinion contains no analysis, the court's theory presumably was that the ERISA plan sponsor would not have intended to incorporate into the plan all state law that would (absent preemption) apply to the plan terms that affirmatively violated ERISA's substantive requirements for benefit plans. Such interpretive reasoning is inapplicable here. The issue is not incorporation of state law by the plan sponsor into an ERISA plan, but rather an insurance company's conformance of its insurance policy to the requirements of state law. The latter has independent legal significance. As previously discussed, HMO insurance (like other health insurance) is sold to individuals and families directly and also to employee benefit plans not governed by ERISA. And even when the insurance is sold to an ERISA plan or plan sponsor, the insurance policy still is not governed exclusively by federal law (unlike the plan itself).

In the insurance situation, therefore, a policy provision incorporating state law should be interpreted in accordance

with its plain meaning. The provision here conforms the HMO policy to state law governing HMO insurance policies, and no exclusion is made for any state law that might otherwise be preempted when the insurance is sold to or for an ERISA plan. Accordingly, the Illinois independent review provision applies here by force of the terms of the HMO policy itself.

VII. If Preemption Were Found, Moran's Appeal On The Breach Of Fiduciary Duty Claim Must Be Decided.

Because the district court asserted jurisdiction on the basis of ERISA preemption, Moran filed an amended complaint with counts under ERISA for breach of contract and breach of the independent review requirement and, alternatively, for breach of fiduciary duty. Rush also obtained summary judgment in the district court on the alternative breach of fiduciary duty count, which Moran also appealed. This issue was not addressed by the Seventh Circuit because it ruled the Illinois independent review law was not preempted as a matter of law and Moran was entitled judgment on that basis.

If this Court reverses, the cause should be remanded to the Seventh Circuit to consider Moran's appeal on the breach of fiduciary duty issue. The factual record, construed most favorably to Moran, demonstrates a question of fact on the reasonableness of Rush's conduct in denying her request for coverage under all the circumstances. *See* R.58, 75-76; Moran's Statement of the Case, *supra*.

The courts of appeal have required under ERISA that insurers, when acting to determine coverage under an insurance contract purchased by an ERISA plan, "are obliged at a minimum to engage in an intensive and scrupulous independent investigation of their options to insure that they

act in the best interest of the plan beneficiaries." *Hightshue v. AIG Life Ins. Co.*, 135 F.3d 1144, 1148 (7th Cir. 1998). Likewise, the Third Circuit in *Heasley v. Belden and Blake Corp.*, 2 F.3d 1249 (3d Cir. 1993), concluded:

> To avoid a conflict of interest, the organization referenced in the [ERISA] plan should be independent. Applying this principle, the Seventh Circuit refused to accord deference to an insurer's denial on an experimental procedure exclusion which defined an experimental procedure so classified by the insurer itself. Any other result, the court reasoned, would enable the insurer "to immunize itself from liability . . . simply by creating a plan which provides that it will deny claims for medical procedures if the insurer's internal advisory committees deem them experimental." *Reilly v. Blue Cross Shield*, 846 F.2d 416, 423 (7th Cir.).

2 F.3d at 1260. That is exactly what Rush has done here. It tries to immunize itself from liability by creating an insurance contract, which provides that it will deny claims for medical procedures if the insurer's administrator deems them not "medically necessary." In this context, the insurer's benefits determination is entitled to a sliding scale of lesser deference down to none, based on the extent of the conflict and the circumstances of the particular denial. *Doe v. Group Hosp. and Med. Serv.*, 3 F.3d 80, 87 (4th Cir. 1993); *Brown v. Blue Cross & Blue Shield of Alabama*, 898 F.2d 1556, 1568 (11th Cir. 1990), *cert. denied*, 498 U.S. 1040 (1991) (burden shifts to conflicted insurer to show independent basis for coverage decision; degree of deference "significantly diminished"). Further, no case has held as Rush claims (Br. 13) that the benefits determination of an insurer of an ERISA benefit must be reviewed under an arbitrary and

capricious standard. *Southern Farm Bureau Life Ins. Co. v. Moore*, 993 F.2d 98, 100 (5th Cir. 1997) (ERISA does not dictate a standard of review of medical necessity decisions).

CONCLUSION

The judgment should be affirmed.

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In the

Supreme Court of the United States

RUSH PRUDENTIAL HMO, INC.,

Petitioner,

v.

DEBRA C. MORAN and STATE OF ILLINOIS,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

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QUESTION PRESENTED

Section 4-10 of the Illinois Health Maintenance Organization Act provides that if a patient's primary care physician deems medically necessary a proposed procedure the patient desires, but the HMO disagrees and denies coverage for the procedure, the patient may have the HMO's decision reviewed by an outside physician, and the HMO must abide by the reviewing physician's determination. The Seventh Circuit held in this case that this independent review mechanism was not preempted by the Employee Retirement Income Security Act ("ERISA").

The question presented is:

Whether the independent review provision of the Illinois HMO Act, which is similar to laws adopted in forty other States and the District of Columbia, is preempted by ERISA.

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STATEMENT OF THE CASE

1. The Illinois Health Maintenance Organization Act

In 1974, the Illinois General Assembly enacted Public Act 78-1151, the Health Maintenance Organization Act ("Act" or "HMO Act"), which is codified at 215 Ill. Comp. Stat. 125/1-1 *et seq*. (2000). The Act defines an HMO as an organization that provides, or arranges and pays for, or reimburses the cost of basic health care services from providers it selects under a system that causes the organization or its providers to bear some part of the risk of health care delivery. 215 Ill. Comp. Stat. 125/1-2 (2000). Among other things, the Act imposes general corporate and financial requirements for all HMOs in Illinois. *See, e.g.*, 215 Ill. Comp. Stat. 125/2-1 to 3-1 (2000). It also sets forth certain medical services that HMOs must provide, including "medically necessary services associated with the administration of a drug" for treatment of certain types of cancer. 215 Ill. Comp. Stat. 125/4-6.3 (2000).

In 1987, the General Assembly amended the HMO Act to address concerns about the operation of HMOs in Illinois. 85th Ill. Gen. Assembly, House of Rep. Proceedings, June 24, 1987 at 233 (comments of Rep. Shaw). One concern was that an HMO enrollee "had nowhere to go" when an HMO refused to provide treatment that the enrollee's primary care physician considered necessary. *Id*. To address this concern, the General Assembly enacted Public Act 85-20, which includes the independent review provision now found at section 4-10 of the HMO Act. 215 Ill. Comp. Stat. 125/4-10 (2000).

Section 4-10 applies when there is a dispute between an HMO enrollee's "primary care physician and the

Health Maintenance Organization regarding the medical necessity of a covered service proposed by a primary care physician." *Id.* Section 4-10 requires all HMOs to provide a mechanism for resolution of such disputes by a physician who is not affiliated with the HMO and who holds the same class of license as the primary care physician. *Id.* The primary care physician, the HMO, and the patient jointly select the reviewing physician. *Id.* If the reviewing physician determines that the covered service proposed by the primary care physician is medically necessary, the HMO must provide the service.[1] 215 Ill. Comp. Stat. 125/4-10 (2000).

2. Ms. Moran's Claim

In January 1998, respondent, Debra C. Moran, sought to invoke her statutory right to independent physician review under section 4-10 in a complaint filed in the Circuit Court of Cook County, Illinois against petitioner, Rush Prudential HMO, Inc. ("Rush"). JA 12-14. Ms. Moran was covered by a medical benefits plan through her husband's employer, and Rush was the plan's HMO

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[1] Under the Illinois Managed Care Reform and Patient Rights Act, which became effective January 1, 2000, the enrollee may seek external independent review of any Managed Care Organization's ("MCO") decision to deny treatment on the ground that the treatment is not medically necessary even if there is no dispute between the enrollee's primary care physician and the MCO about this issue. 215 Ill. Comp. Stat. 134/45(f) (2000). The Managed Care Reform and Patient Rights Act was not in effect at the time of the relevant events in this case. This act did not repeal or amend section 4-10 of the HMO Act, which remains in effect.

provider. Pet. App. 3a. The dispute between Rush and Ms. Moran arose from treatment she sought in 1996 for pain, numbness, decreased mobility, and loss of function in her right shoulder. *Id.* Ms. Moran's primary care physician was Dr. Arthur LaMarre, who was affiliated with Rush. *Id.*

Dr. LaMarre prescribed physiotherapy and other conservative therapies for Ms. Moran, but her symptoms did not subside. *Id.* at 3a-4a. Ms. Moran then traveled to Virginia at her own expense to see Dr. Julia Terzis, a specialist in microreconstructive surgery. *Id.* at 4a. Dr. Terzis diagnosed Ms. Moran as suffering from brachial plexopathy and thoracic outlet syndrome ("TOS"), a syndrome resulting from the compression of nerves in her brachial plexus. *Id.* Dr. Terzis recommended that Ms. Moran undergo a surgical procedure consisting of removal of the uppermost rib and the attached muscle and, if indicated during the course of the procedure, microneurolysis of the lower roots of the brachial plexus under intraoperative microscopic magnification. *Id.* After she returned home from Virginia, two thoracic surgeons affiliated with Rush examined Ms. Moran and recommended instead the standard surgical procedure for TOS, which does not involve microneurolysis. *Id.* at 5a.

Ms. Moran decided, however, that she wished to have the surgical procedure recommended by Dr. Terzis. *Id.* On October 14, 1997, Dr. LaMarre sent a letter to Rush stating that Ms. Moran would be "best served" by having Dr. Terzis' proposed surgery and asking Rush to approve the procedure. *Id.* Rush denied the request and after Ms. Moran appealed internally Rush affirmed the denial of coverage on the ground that the procedure was not "medically necessary" under the plan's definition of that term. *Id.* Rush's Membership Advisory Committee upheld the

denial after Ms. Moran made her final internal appeal to that body. *Id.*

In January 1998, Ms. Moran sent Rush a written demand for independent external review of the coverage denial in accordance with section 4-10 of the Illinois HMO Act. *Id.* Rush did not act on this request, and Ms. Moran filed her complaint in the Circuit Court of Cook County, Illinois later that month. *Id.* In the complaint, she asked the court to order Rush to agree to the appointment of an independent reviewing physician pursuant to section 4-10 to consider the medical necessity of the surgery proposed by Dr. Terzis. JA 14. Rush removed the complaint to the United States District Court for the Northern District of Illinois, but the district court remanded the case to the state court because Ms. Moran's action did not involve a federal claim. Pet. App. 7a. In the meantime, Dr. Terzis performed the microneurolysis surgery upon Ms. Moran, and she incurred costs of $94,841.27. *Id.* at 6a.

The Circuit Court of Cook County entered an order on November 2, 1998 granting in part Ms. Moran's motion for judgment on the pleadings and directing Rush to provide independent review pursuant to section 4-10 of the HMO Act regarding the medical necessity of the surgery performed by Dr. Terzis. JA 15-16. Rush complied with this order, and the independent review was performed by Dr. Lee Dellon, who specialized in plastic and reconstructive surgery at the Johns Hopkins Medical Center. Pet. App. 7a. Dr. Dellon concluded that the surgery performed by Dr. Terzis was medically necessary, although he indicated that he would have used a different technique in performing the microneurolysis. Pet. App. 8a.

After Dr. Dellon finished his independent review, Rush again considered whether Ms. Moran's surgery was covered, and it denied the claim again in January 1999. *Id.* Ms. Moran then amended her complaint to add allegations that Rush had declined to pay for her surgery despite the independent reviewer's conclusion that it was medically necessary. *Id.* at 20-21; JA 17-22. Ms. Moran sought a judgment directing Rush, among other things, to pay for the cost of her surgery and post-operative care. JA at 21-22.

After Ms. Moran amended her complaint, Rush removed the case to federal court a second time. Pet. App. 8a. Ms. Moran sought a remand to state court, but the district court denied her motion on the basis that her claim for reimbursement arose under federal law because it was a claim for plan benefits that fell within § 502(a)(1)(B) of the civil enforcement provision of the Employee Retirement Security Income Act of 1974 ("ERISA"), 29 U.S.C. § 1132(a)(1)(B). Pet. App. 8a-9a, 38a-43a. In the order denying remand, the district court also concluded that section 4-10 of the Illinois HMO Act was not saved from preemption by ERISA's "savings" clause, which provides that ERISA does not preempt state laws that regulate insurance. 29 U.S.C. § 1144(b)(2)(A). The district court concluded that section 4-10 of the HMO Act was not a law regulating insurance because the provision does not spread or transfer the policyholder's risk. Pet. App. 42a. The district court denied Ms. Moran's motion for reconsideration. Pet. App. 46a.

After her motion to remand to state court was denied, Ms. Moran filed a second amended complaint in which she added a new claim under section 502(a) of ERISA, 29 U.S.C. § 1132(a). JA 23. Rush moved for summary

judgment, and the district court granted the motion. Pet. App. 10a. The district court noted that the employee benefit plan gave Rush broad discretion to make benefit determinations, and it ruled that Rush was entitled to summary judgment because it had not abused its discretion or acted in an arbitrary manner in denying Ms. Moran's benefit claim. *Id.*

3. The Seventh Circuit's Decision

Moran appealed to the United States Court of Appeals for the Seventh Circuit. *Id.* at 2a. The Seventh Circuit allowed the State of Illinois to intervene to defend section 4-10 of its HMO Act. *Id.* On October 19, 2000, the court issued a decision reversing the district court and concluding that Ms. Moran rather than Rush was entitled to summary judgment. Pet. App. 1a-24a.

Initially, the Seventh Circuit concluded that Ms. Moran's action was properly removed to federal court because it was a claim under 29 U.S.C. § 1132(a)(1)(B) to enforce her rights under an ERISA plan. Pet. App. 11a-13a. The court went on to conclude that ERISA's insurance savings clause, 29 U.S.C. § 1144(b)(2)(A), applied and saved section 4-10 of the HMO Act because it is a law that regulates insurance as a matter of common sense, and it satisfies two of the three factors traditionally examined in determining whether a state law regulates insurance. Pet. App. 16a-18a. These factors, known as the McCarran-Ferguson factors,[2] are whether the law: (1) has the effect of spreading or transferring the policy-

[2] These factors are used in determining whether a law regulates the "business of insurance" under the McCarran-Ferguson Act. 15 U.S.C. § 1011, *et seq.*

holder's risk; (2) is an integral part of the relationship between the insurer and the insured; and (3) is limited to entities in the insurance industry. Pet. App. 16a-17a. The Seventh Circuit explained that section 4-10 regulates insurance as a matter of common sense because HMOs are insurance vehicles and the provision is "directed to the HMO industry as insurers." Pet. App. 17a.

The court also found that two of the McCarran-Ferguson factors were met. According to the court, the second factor was met because laws like section 4-10 that effectively mandate terms in insurance contracts change the bargain between insurer and insured and are therefore integral parts of the relationship between them. *Id.* at 17a-18a. Section 4-10 also satisfied the third McCarran-Ferguson factor because it was limited to entities in the insurance industry. *Id.* at 18a. Under these circumstances, the court concluded that section 4-10 was a law that regulated insurance within the meaning of the savings clause.[3] *Id.* at 17a-18a.

After determining that the savings clause applied to section 4-10, the court considered whether section 4-10 was nonetheless preempted because it conflicted with ERISA's civil enforcement scheme by providing an alternative remedy. *Id.* at 19a-23a. The Seventh Circuit concluded that section 4-10 does not create an alternative

[3] The Seventh Circuit also held that ERISA's "deemer" clause, 29 U.S.C. § 1144(b)(2)(B), does not apply to section 4-10. Pet. App. at 18a-19a. The court stated that the deemer clause only shields self-funded plans from state laws that regulate insurance, and the plan in this case is an insured plan. *Id.* Rush has not raised an argument based on the deemer clause in its opening brief in this Court.

remedy that conflicts with section 502(a)(1)(B) of ERISA, 29 U.S.C. § 1132(a)(1)(B), which gives plan beneficiaries and participants the right to sue to recover benefits or to enforce or clarify rights under the plan. *Id.* at 21a-22a. Because the terms of section 4-10 were incorporated into Ms. Moran's insurance contract as a matter of law, the court concluded that her lawsuit to enforce her rights under section 4-10 was an action to enforce her rights and recover benefits under the plan, exactly the type of suit that section 502(a) of ERISA contemplates. *Id.* at 21a. Therefore, section 4-10 does not create a remedy that conflicts with ERISA. Instead, it merely creates an additional mechanism for making decisions about medical necessity when the HMO and the patient's primary care physician disagree. *Id.* at 21a-22a.

The Seventh Circuit acknowledged that its decision on this issue conflicted with *Corporate Health Ins. Co. v. Texas Dept. of Ins.*, 215 F.3d 526 (5th Cir. 2000). Pet. App. at 20a-21a. Because of the conflict, the Seventh Circuit circulated the opinion prior to publication for a vote on whether the case should be heard *en banc*. *Id.* at 23a. A majority of the Seventh Circuit judges voted not to hear the case *en banc*, but four judges dissented from the denial of rehearing *en banc*. *Id.* at 23a-27a.

SUMMARY OF ARGUMENT

ERISA's savings clause states that nothing in the ERISA preemption provision "shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." 29 U.S.C. § 1144(b)(2)(A). The savings clause expresses Congress' desire that States retain the authority to regulate the business of insurance. Section 4-10 of the Illi-

nois HMO Act is a law that regulates insurance under the criteria set forth by this Court in several cases. The savings clause therefore applies to section 4-10 and saves it from preemption.

In resolving whether a state law regulates insurance for purposes of the savings clause, the first question is whether the law regulates insurance as a matter of common sense. *UNUM Life Ins. Co. of America v. Ward*, 526 U.S. 358, 367 (1999). The other question is whether the law satisfies the factors used to determine whether a state law regulates the business of insurance under the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.* *UNUM*, 526 U.S. at 373. These factors are guideposts that need not all be satisfied. *Id.* at 374.

Section 4-10 regulates insurance as a matter of common sense. A law regulates insurance as a matter of common sense when it is directed toward the insurance industry. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50 (1987). Section 4-10 applies only to HMOs, "entities that are engaged in the business of health insurance." *Washington Physicians Service Ass'n v. Gregoire*, 147 F.3d 1039, 1045 (9th Cir. 1998), *cert. denied*, 525 U.S. 1141 (1999). As the Seventh Circuit concluded here, section 4-10 is "aimed exclusively at members of the insurance industry," and the provision therefore regulates insurance under a common-sense understanding of the matter. Pet. App. 17a-18a.

Section 4-10 also satisfies all three McCarran-Ferguson factors. The first factor is satisfied because the provision transfers risk to HMOs. Because of the independent external review provided by section 4-10, HMO enrollees in Illinois run less risk of having medical services denied on the basis that they are not medically neces-

sary. Section 4-10 achieves the transfer of risk and confers a benefit upon HMO enrollees because they will not have to pay for medical treatment as often as a result of the provision. The second factor is met because laws that change the bargain in an insurance contract by effectively adding contract terms form an integral part of the relationship between the insurer and the insured. *UNUM*, 526 U.S. at 374. Section 4-10 is such a law. The third McCarran-Ferguson factor is met because section 4-10 is limited to entities in the insurance industry, as stated above.

Furthermore, section 4-10 does not conflict with any provision of ERISA so there is no preemption on this basis. The independent external review requirement of section 4-10 does not conflict with the remedial scheme set forth in section 502(a) of ERISA, 29 U.S.C. § 1132(a). Section 4-10 merely provides for an additional review mechanism when an HMO and an enrollee's primary care physician disagree about whether treatment is medically necessary. This review mechanism is similar to binding arbitration, and federal circuits have consistently concluded that mandatory arbitration provisions in employee benefit plans do not conflict with ERISA. *See, e.g., Kramer v. Smith Barney*, 80 F.3d 1080, 1084 (5th Cir. 1996) (citing cases).

Unlike the common-law rule at issue in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 49-50 (1987), section 4-10 does not create a cause of action or a new remedy for the denial of plan benefits. But, because the right to independent external review set forth in section 4-10 is effectively incorporated into all HMO coverage in Illinois as a matter of law, this right may be pursued in an action brought under section 502(a)(1)(B) of ERISA.

There is also no conflict between section 4-10 and the requirement of "full and fair" internal fiduciary review of adverse benefit claim determinations set forth in section 533 of ERISA, 29 U.S.C. § 1133. Section 4-10 does not supplant the requirements of section 533 in any manner. Instead, section 4-10 adds the requirement of external review under certain circumstances. Section 4-10 of the HMO complements rather than contradicts section 533 of ERISA, which is intended to protect plan beneficiaries.

Finally, the savings clause unambiguously exempts state laws regulating insurance like section 4-10 from ERISA preemption without exception. When a statute is unambiguous, the judicial inquiry about its meaning is at an end, and the provision should be enforced as written. *Connecticut Nat'l Bank v. Germain*, 503 U.S. 249, 254 (1992). Thus, even if section 4-10 conflicts with an ERISA provision, the savings clause saves the independent external review requirement from preemption.

ARGUMENT

I. INTRODUCTION

The Illinois General Assembly enacted section 4-10 of the Illinois HMO Act to give an HMO enrollee recourse when the enrollee's physician believes medical treatment is necessary but the HMO refuses to provide it. 85th Ill. Gen. Assembly, House of Rep. Proceedings, June 24, 1987, at 233 (comments of Rep. Shaw). Legislative bodies in forty other states and the District of Columbia have passed similar laws requiring independent external review of medical necessity decisions of HMOs under certain circumstances in order to assure that HMO cov-

erage is meaningful.[4] These laws are entirely consistent with ERISA's objective of protecting plan participants and their beneficiaries. 29 U.S.C. § 1001(b).

Rush nonetheless argues that these beneficiaries cannot avail themselves of the protection of independent external review laws like section 4-10 because ERISA preempts them. In making this argument, Rush fails to recognize the presumption that ERISA does not preempt state law when the state is exercising its historic police

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[4] *See* Alaska Stat. § 21.07.050 (Michie 2001); Ariz. Rev. Stat. Ann. § 20-2537 (2000); Cal. Ins. Code § 10169 (2001); Colo. Rev. Stat. § 10-16-113.5 (2000); Conn. Gen. Stat. § 38a-478n (2001); 16 Del. Code Ann. § 9119 (2000); D.C. Code § 32-571.7 (2000); 2000 Fla. Laws ch. 00-256; Ga. Code Ann. § 33-20A-32 (2000); Hi. Rev. Stat. § 432E-6 (2000); 215 Ill. Comp. Stat. 125/4-10 (2000); Ind. Ins. Code Ann. § 27-13-10.1-1 (2000); Iowa Code Ann. § 514J (2000); Kan. Stat. Ann. § 40-22a13 (2000); Ky. Rev. Stat. § 304.17A-623 (2001); La. Rev. Stat. 22:3081 (2000); 24-A Me. Rev. Stat. § 4312 (2000); Md. Ins. Code Ann. § 15-10A-01 (2001); Mass. Ann. Laws Ann. ch. 1760 § 14 (2001); Mich. Comp. Laws § 550.1907 (2001); Minn. Stat. § 62Q.73 (2000); Rev. Stat. Mo. § 376.1385 (2000); Mont. Code Ann. § 33-37-102 (2000); N.H. Rev. Stat. Ann. 420-J:5 (2000); N.J. Stat. § 26:2S-11 (2001); 13 N.M. Adm. Code § 10.17.24 (2000); N.Y. Ins. Law § 4904 (McKinney 1999); N.C. Gen. Stat. § 58-50-62 (1999); Ohio Rev. Code Ann. § 1751.84 (Anderson 2001); 63 Okl. St. § 2528.3 (2000); Oregon Laws, ch. 266, § 8 (2001); 40 Pa. Cons. Stat. § 991.2162 (1998); R.I. Gen Laws § 23-17.12-10 (2001); S.C. Code Ann. § 38-71-1970 (2000); Tenn. Code Ann. § 56-32-227 (2001); Tex. Ins. Code art. 21.58A (Vernon Supp. 2001); Utah Code Ann. § 31A-22-629 (2000); 8 Vt. Stat. Ann. § 4089 (2001); Va. Code Ann. § 38.2-5901 *et seq.* (2001); Rev. Code Wash. 48.43.535 (2001); W. Va. Code § 33-25C-6 (2001); Wis. Stat. § 632.835 (2000).

powers. *New York Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995). States have traditionally regulated the business of insurance, as Congress recognized when it enacted the McCarran-Ferguson Act, which provides that federal antitrust laws apply to the business of insurance only to the extent that this business is not regulated by state law. 15 U.S.C. § 1012. Congress also recognized that the regulation of insurance was traditionally a state matter when it enacted ERISA's savings clause, 29 U.S.C. § 1144(b)(2)(A), which exempts state laws regulating insurance from ERISA preemption. *FMC Corp. v. Holliday*, 498 U.S. 52, 63 (1990).

Under section 514(a) of ERISA, state laws are generally preempted if they "relate to any employee benefit plan." 29 U.S.C. § 1132(a); *UNUM Life Ins. Co. of America v. Ward*, 526 U.S. 358, 363 (1999). ERISA's savings clause qualifies this provision by excepting from preemption state laws that regulate insurance, banking, or securities. 29 U.S.C. § 1144(b)(2)(A). This allows states to regulate an insured ERISA plan indirectly by regulating its insurer and the insurer's insurance contracts. *FMC Corp.*, 498 U.S. at 64. As this Court has recognized, documents that create an HMO are not themselves an ERISA plan, but an agreement between an employer and an HMO may set forth elements of an ERISA plan by setting forth rules under which beneficiaries are entitled to medical care. *Pegram v. Herdrich*, 530 U.S. 211, 223 (2000).

The Seventh Circuit held that section 4-10 relates to employee benefit plans, but ERISA does not preempt section 4-10 because the savings clause applies. Pet. App. 14a-23a. This Court should affirm the Seventh Circuit. Section 4-10 of the HMO Act is an exercise by

the Illinois General Assembly of the traditional authority of states to regulate insurance. Consequently, the savings clause excepts section 4-10 from preemption.

II. ERISA DOES NOT PREEMPT SECTION 4-10 OF THE HMO ACT BECAUSE IT IS A STATE LAW THAT REGULATES INSURANCE.

A. The ERISA Savings Clause Saves From Preemption A State Law That Regulates Insurance Even If The Law Has An Adverse Impact On The Uniform Administration of ERISA Plans.

ERISA's savings clause expresses Congress' intent to avoid interference with the traditional powers of the states to regulate the business of insurance. *FMC Corp.*, 498 U.S. at 63. The clause saves from preemption state laws that regulate insurance even if the laws have an adverse impact on the uniform administration of ERISA plans. *UNUM*, 526 U.S. at 376, n.6; *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 722, 746-47 (1985). Nothing in ERISA's language, structure or legislative history supports a more restrictive reading of the savings clause. *Metropolitan Life*, 471 U.S. at 746.

Congress' decision to save from preemption state laws that regulate insurance inevitably causes some lack of uniformity in plan administration. *Id.* at 747. Arguments about the wisdom of this policy decision, however, should be directed to Congress rather than the courts. *Id.* The savings clause applies and saves section 4-10 from preemption if it is a law regulating insurance, even if the independent physician review requirement interferes with the uniform administration of ERISA plans, as Rush contends. Pet. Br. at 26.

B. Section 4-10 Of The HMO Act Regulates Insurance As A Matter Of Common Sense And It Satisfies All Three Factors Used To Determine Whether A Practice Constitutes The Business Of Insurance Under The McCarran-Ferguson Act.

The framework for determining whether a state law regulates insurance within the meaning of the savings clause is well-established. The first step is to consider whether a common-sense understanding of the matter indicates that the law regulates insurance. *UNUM*, 526 U.S. at 367; *Metropolitan Life*, 471 U.S. at 740. The next step is to examine whether the law satisfies the three factors used to determine whether a practice constitutes the business of insurance under the McCarran-Ferguson Act, 15 U.S.C. §§ 1011 *et seq*. *UNUM*, 526 U.S. at 367; *Metropolitan Life*, 471 U.S. at 740. These three factors are: (1) whether the practice in question has the effect of transferring or spreading policyholder risk; (2) whether the law regulates an integral part of the relationship between the insurer and the insured; and (3) whether the law applies only to entities in the insurance industry. *Metropolitan Life*, 471 U.S. at 743. These factors are guideposts in determining whether a state law regulates insurance; they are not essential elements that must all be satisfied to save the state law from preemption. *UNUM*, 526 U.S. at 373-74.

1. Section 4-10 Regulates Insurance As A Matter Of Common Sense.

State laws that are directed specifically at the insurance industry are laws that regulate insurance from a common-sense perspective. *UNUM*, 526 U.S. at 368.

Section 4-10 of the Illinois HMO Act regulates insurance as a matter of common sense because it applies solely to health maintenance organizations, "entities that are engaged in the business of health insurance." *Washington Physicians Service Ass'n v. Gregoire*, 147 F.3d 1039, 1045 (9th Cir. 1998), *cert. denied*, 525 U.S. 1141 (1999) (savings clause applied to Washington law regulating HMOs and other insurers).

As the court pointed out in *Washington Physicians*, insurance is characterized by the acceptance of risks and the spreading of resulting losses over all the risks so that the insurer can accept each risk at a slight fraction of the possible liability upon the insurer. *Washington Physicians*, 147 F.3d at 1045. The only difference between an HMO and a traditional health insurer is that the HMO provides medical services directly while the traditional insurer does so indirectly by paying for the services, but this is "a distinction without a difference." *Id.* at 1045-46. HMOs essentially operate in the same manner as traditional health insurers; the policyholder pays a fee in exchange for a promise that he or she will receive medical services when necessary. *Id.*

The Sixth Circuit recently cited *Washington Physicians* in support of its conclusion that HMOs are insurers. *Kentucky Ass'n of Health Plans, Inc. v. Nichols*, 227 F.3d 352, 364-65 (6th Cir. 2000), *petition for cert. filed*, No. 00-1471 (savings clause applied to "any willing provider law"). Other circuits have reached the same conclusion. *Express Scripts, Inc. v. Wenzel*, 262 F.3d 829, 835 (8th Cir. 2001) (savings clause applied to Missouri law regulating HMO prescription drug coverage); *Anderson v. Humana, Inc.*, 24 F.3d 889, 892 (7th Cir. 1994) (HMOs are "insurance vehicles under Illinois law"); *In re Medcare HMO*, 998 F.2d 436, 444-45 (7th Cir. 1993) (HMO's

are "the substantial equivalents of domestic insurance companies"); *but see O'Reilly v. Ceuleers*, 912 F.2d 1383, 1389 (11th Cir. 1990) (HMOs are not insurers). Even the Fifth Circuit, which held that a Texas independent external review law was preempted, held in the same case that HMOs are insurers, and the insurance savings clause applied to the challenged provision. *Corporate Health Ins. Co. v. Texas Dep't. of Ins.*, 215 F.3d 526, 537-38 (5th Cir. 2000), *petition for cert. filed*, No. 00-665.

Rush contends that section 4-10 does not regulate insurance as a matter of common sense because the law applies to HMOs even when they are acting solely as third-party administrators of plans, and not as insurers.[5] Pet. Br. at 39. The *amici* supporting Rush echo this argument. *Amicus* brief of American Association of Health Plans, Inc. *et al.*, p. 21. The concerns of Rush and *amici* are unfounded.

The Illinois HMO Act defines a health maintenance organization as "any organization formed under the laws of this or another state to provide or arrange for one or more health care plans under a system which causes any part of the risk of health care delivery to be born by the organization or its providers." 215 Ill. Comp. Stat. 125/1-2 (2000). In light of the Act's definition of the term "health maintenance organization," section 4-10 only ap-

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[5] Although Rush now argues that section 4-10 is too broad to be considered a law regulating insurance, it argued in the Seventh Circuit that section 4-10 was too narrow to qualify as such because it did not apply to all insurers. The Seventh Circuit rejected this argument (Pet. App. 17a), and Rush has not raised the argument in this Court. Rush acted as an insurer here because the plan at issue was an insured plan. Pet. App. 18a.

plies when HMOs are involved in the spreading or transfer of risk, which this Court has recognized as an important characteristic of the business of insurance. *UNUM*, 526 U.S. at 374; *Metropolitan Life*, 471 U.S. at 743. Thus, when HMOs act solely as third-party administrators of a plan and are not involved in the spreading or transfer of risk, section 4-10 does not apply to them.

Rush mentions examples in its brief of HMOs sharing risk with other entities through methods such as capitated arrangement with physician groups, and Rush argues that HMOs are not acting as insurers when they enter into such arrangements.[6] Pet. Br. at 38. But an HMO's transfer of risk to a physician provider group under a capitated contract does not entirely relieve the HMO of risk because it does not relieve the HMO of its contractual obligation to provide health care to its subscribers. *See* Overbay and Hall, *Insurance Regulation of Providers That Bear Risk*, 22 Am. J. L. and M. 361, 372 (1996). For example, in the event the provider group becomes insolvent, the HMO is still obligated to provide health care to its subscribers. *Id.* Thus, an HMO is still bearing risk, and it is still acting as an insurer even when it enters into a risk-sharing arrangement with a third party. Section 4-10 therefore applies to HMOs only when they are acting as insurers.[7]

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[6] For a discussion of capitation and other risk-sharing arrangements employed by HMOs, see Hampton, *Resurrection of the Prohibition on the Corporate Practice of Medicine: Teaching Old Dogma New Tricks*, 66 U. Cin. L. Rev. 489, 506-07 (1998).

[7] The *amici* supporting Rush argue that section 4-10 applies to HMOs that merely act as administrators for self-insured (continued...)

The fact that section 4-10 applies to insurance contracts is a further indication that the provision regulates insurance as a matter of common sense. In this respect, section 4-10 of the Illinois HMO Act has an effect similar to the state laws that were saved from ERISA preemption under this Court's holdings in *Metropolitan Life* and *UNUM*. *Metropolitan Life* involved a Massachusetts statute requiring any general health insurance policy to contain, at a minimum, certain coverage for persons suffering from mental illnesses, including coverage for at least 60 days of confinement in a mental hospital. *Metropolitan Life*, 471 U.S. at 730. This Court held that the savings clause applied to that statute because it regulated the terms of insurance policies and mandated benefits. *Id.* at 742-44. Similarly, in *UNUM*, the Court held that the savings clause applied to a California common-law rule under which an insurer had to show actual prejudice in order to justify denying coverage for

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[7] (...continued)
ERISA plans. *Amicus* brief of American Association of Health Plans, Inc., et al., p. 21. In light of the Illinois HMO Act's definition of "health maintenance organization" discussed above, this argument is without merit. Furthermore, even if section 4-10 did apply to HMOs when they act as administrators of self-insured plans, Illinois could still apply the provision to those HMOs when they act as insurers. ERISA's so-called "deemer" clause, 29 U.S.C. § 1144(b)(2)(B), which states that a benefit plan shall not be deemed an insurance company for purposes of the savings clause, would merely preclude application of section 4-10 to HMOs when they administer self-insured plans. *See Metropolitan Life*, 471 U.S. 724, 735-36, n.14 (1985) (interpreting the deemer clause as exempting self-funded ERISA plans from state laws that regulate insurance within the meaning of ERISA's savings clause).

failure to comply with a policy deadline for providing notice of a claim. *Id.* at 366-67. The Court stated that the California rule effectively created a mandatory contract term under which insurers had to show actual prejudice before they could enforce a timeliness-of-claim provision in an insurance policy. *Id.* at 374.

Likewise, section 4-10 effectively creates a mandatory contract term in HMO coverage in Illinois. Illinois courts apply the general insurance law principle that statutory provisions that apply to insurance contracts become a part of all such contracts as though they were actually incorporated in them. *Plumb v. Fluid Pump Service, Inc.*, 124 F.3d 849, 861 (7th Cir. 1997); *Harris v. St. Paul Fire & Marine Ins. Co.*, 248 Ill. App. 3d 52, 618 N.E.2d 330, 333 (1st Dist. 1993). Thus, as the Seventh Circuit concluded, the provisions of section 4-10 are substantive terms of all HMO coverage in Illinois by operation of law. Pet. App. at 17a. Like the state laws at issue in *Metropolitan Life* and *UNUM*, section 4-10 effectively creates a mandatory contract term. Because section 4-10 is limited to entities in the insurance industry and it applies to insurance contracts, the provision regulates insurance as a matter of common sense. *UNUM*, 526 U.S. at 368.

2. Section 4-10 Satisfies All Three McCarran-Ferguson Factors.

Section 4-10 also satisfies all three of the McCarran-Ferguson factors, although they need not all be satisfied for the savings clause to apply. *UNUM*, 526 U.S. at 374. In *UNUM*, the Court held that the savings clause applied when California's notice-prejudice rule regulated

insurance as a matter of common sense, and it satisfied the second and third McCarran-Ferguson factors. *Id.* at 373-76. The Seventh Circuit correctly reached the same conclusion for the same reason here. Pet. App. at 18a. Section 4-10 satisfies the second McCarran-Ferguson factor, which is whether the provision regulates an integral part of the relationship between the insurer and the insured. *UNUM*, 526 U.S. at 374. In *UNUM*, California's notice-prejudice rule satisfied the second McCarran-Ferguson criterion because it changed the bargain in an insurance contract by effectively creating a mandatory contract term requiring insurers to prove prejudice before they denied coverage on the basis of an untimely claim. *Id.* The rule, therefore, dictated terms of the relationship between the insurer and insured and served as an integral part of the relationship between them. *Id.* at 374-75.

The same is true of section 4-10, which is actually incorporated into HMO coverage by operation of Illinois law and thereby creates a mandatory contract term. *See Plumb*, 124 F.3d at 861. Like the rule at issue in *UNUM*, section 4-10 limits the ability of the insurer, in this case the HMO, to deny coverage under the circumstances specified therein. Because section 4-10 dictates terms of the insurance relationship between HMOs and enrollees, it serves as an integral part of the relationship between them. *UNUM*, 526 U.S. at 374. Section 4-10 also satisfies the third McCarran-Ferguson factor, which is whether the law applies only to entities in the insurance industry. *Metropolitan Life*, 471 U.S. at 743. As discussed above, section 4-10 applies to HMOs only when they are acting as insurers.

Like the *UNUM* Court, the Seventh Circuit found it unnecessary to consider the first McCarran-Ferguson

factor, which is whether the provision achieves the transfer or spreading of risk, because it found that the other two factors were satisfied. Pet. App. at 16a-18a. If this Court decides to address the first factor, it should find that the factor is satisfied because section 4-10 has the effect of transferring policyholder risk to the HMO.

Rush contends that section 4-10 does not transfer risk because it does not affect an enrollee's coverage rights, as Rush is required to pay for medically necessary services under the plan irrespective of section 4-10. Pet. Br. at 41. But, in enacting section 4-10, the Illinois legislature provided that an HMO's decision to deny coverage on the basis that a covered service is not medically necessary will not be the final word on the matter if the patient's primary care physician disagrees with the determination. In that event, an independent physician makes a binding determination as to whether the requested care is medically necessary. 215 Ill. Comp. Stat. 125/4-10 (2000). The Illinois legislature undoubtedly contemplated that there would be situations in which an HMO's denial of coverage on medical necessity grounds would be overturned by the independent reviewing physician. Thus, the Illinois legislature made a conscious decision to transfer a greater degree of risk to HMOs because the independent external review requirement increases the number of situations in which HMOs will be required to pay for medical services because they are medically necessary. Section 4-10 thereby accomplishes the transfer of risk by shifting more risk from the insured to the insurer. *See Washington Physicians*, 147 F.3d at 1046.

Additionally, in arguing that the first McCarran-Ferguson factor is not satisfied, Rush cites *Union Labor Life Insurance Co. v. Pireno*, 458 U.S. 119, 130-31 (1982), for

the proposition that the insurance policy defines the risk assumed by the insurer and the transfer of risk is completed at the time the parties enter into the insurance contract. Pet. Br. at 40. But Rush overlooks the fact that the independent physician review requirement of section 4-10 became part of the insurance contract at issue here by operation of Illinois law. *Plumb*, 124 F.3d at 861. The provision is therefore part of the insurance contract that defines the risk transferred to the insurer, and it is connected to the spreading of risk achieved by that contract. *See Pireno*, 458 U.S. at 130.

In sum, section 4-10 of the HMO Act regulates insurance as a matter of common sense, and it also satisfies all three McCarran-Ferguson factors. Therefore, as the Seventh Circuit concluded, the ERISA savings clause applies to section 4-10 and saves it from preemption. Pet. App. at 16a-18a.[8]

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[8] Rush has not argued in its opening brief that ERISA's deemer clause (29 U.S.C. § 1144(b)(2)(B)) applies here, and the Seventh Circuit correctly ruled that it does not. Pet. App. at 18a-19a. The Seventh Circuit stated that the deemer clause only shields self-funded plans from state laws that regulate insurance, and the plan at issue in this case is an insured plan. *Id.*, citing *UNUM*, 526 U.S. at 367, n.2.

III. SECTION 4-10 OF THE HMO ACT DOES NOT CONFLICT WITH THE CIVIL ENFORCEMENT SCHEME IN SECTION 502(a) OF ERISA OR WITH ANY OTHER ERISA PROVISION.

A. Unlike The Mississippi Common-Law Rule At Issue In *Pilot Life*, Section 4-10 Does Not Create A Cause Of Action That Provides A Remedy For An ERISA Violation.

The ERISA savings clause reflects that Congress intended to allow dual regulation under ERISA and state insurance law. *John Hancock Life Ins. Co. v. Harris Trust and Savings Bank*, 510 U.S. 86, 100 (1993). Under these circumstances, state law must yield only when there is a direct conflict with federal law. *Id.* There is no such conflict here. The Seventh Circuit correctly rejected Rush's argument that section 4-10 is preempted because it conflicts with the remedies provided in the civil enforcement scheme in section 502(a) of ERISA, 29 U.S.C. § 1132(a).

Among the remedies set forth in section 502(a) of ERISA are the right of a plan beneficiary to sue in order to: (1) recover benefits due under the plan, (2) enforce the beneficiary's rights under the plan, and (3) to clarify his or her right to future benefits. 29 U.S.C. § 1132(a). Section 4-10 of the Illinois HMO Act does not conflict with the remedial scheme prescribed by Congress in section 502(a). Instead, section 4-10 merely requires an additional review mechanism akin to arbitration when an HMO and an enrollee's treating physician disagree about whether treatment for an enrollee is medically necessary. Federal circuits that have considered the issue have consistently concluded that mandatory arbitration provisions in ERISA plans do not conflict with ERISA. *See, e.g., Kramer v. Smith Barney*, 80 F.3d 1080, 1084 (5th Cir. 1996) (citing cases).

Rush relies primarily upon *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) in support of its preemption argument based upon an alleged conflict with section 502(a) of ERISA. The Court held in *Pilot Life* that ERISA preempted a Mississippi common-law cause of action for punitive damages for bad faith in breaching a contract. *Id.* at 45-57. Initially, the Court held that this common-law cause of action related to an employee benefit plan, and it therefore fell within the preemption clause in section 514(a) of ERISA, 29 U.S.C. § 1132(a). *Pilot Life*, 481 U.S. at 47. The Court went on to consider the plaintiff's argument that the ERISA savings clause applied and saved the state-law claim for bad faith as a law that regulates insurance. *Id.* In rejecting this contention, the Court held that the savings clause did not apply because the rule applied to entities outside the insurance industry, and allowed punitive damages whenever an act or omission constituting a breach of contract also constituted an independent tort. *Pilot Life*, 481 U.S. at 49-50. Because "[a]ny breach of contract, and not merely breach of an insurance contract" could result in punitive damages, the rule did not regulate insurance, and the savings clause did not apply to it. *Pilot Life*, 481 U.S. at 50.

By contrast, section 4-10 applies only to HMOs, "entities that are engaged in the business of health insurance." *Washington Physicians*, 147 F.3d at 1045. For this reason, the savings clause applies to the independent physician review provision. Like the California notice-prejudice rule at issue in *UNUM*, section 4-10 is a law "firmly applied to insurance contracts, not a general principle guiding a court's discretion in a range of matters." *UNUM*, 526 U.S. at 371. This factor distinguishes section 4-10 from the common-law cause of action at issue in *Pilot Life*.

The Court also held in *Pilot Life* that ERISA preempted Mississippi's bad-faith cause of action because Mississippi provided a remedy for the wrongful denial of benefits in addition to those provided in ERISA's civil enforcement scheme, 29 U.S.C. § 1132(a), which Congress intended to be exclusive. *Pilot Life*, 481 U.S. at 51-57. Section 4-10 differs from the Mississippi common-law rule in that the independent external review provision does not establish a cause of action in which a remedy such as punitive damages may be awarded for the wrongful denial of ERISA benefits. This factor distinguishes the case at bar from *Pilot Life* and two other cases relied upon by Rush, *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 140-45 (1990) (holding that ERISA preempted state common law cause of action for wrongful discharge), and *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 62 (1985) (holding that ERISA preempted state common-law tort and contract claims).

Rush expresses a fear that adoption of the Seventh Circuit's reasoning in this case will permit states to subvert section 502(a) of ERISA by deeming state laws providing remedies that are inconsistent with ERISA's civil enforcement scheme to be plan terms. Pet. Br. at 27a. But the Seventh Circuit's decision does not allow states to evade section 502(a) by "recasting prohibited alternative remedies as mandated contract terms" as Rush contends. Pet. Br. at 28-29. Rush's argument is unfounded because, unlike the state laws at issue in *Pilot Life*, *Ingersoll-Rand*, and *Taylor*, section 4-10 does not create a state-law remedy for the denial of benefits under an ERISA plan.

This case illustrates why section 4-10 does not provide such a remedy. Here, Rush persisted in its refusal to pay for Moran's surgery after the independent reviewing

physician determined that it was medically necessary. Pet. App. 8a. The employment of the independent physician review mechanism did not, by itself, provide any relief to Moran. Instead, even after the review took place, Moran had to pursue her cause of action against Rush for payment of the costs relating to her surgery. The Seventh Circuit concluded that this was a claim for plan benefits that had to be brought under section 502(a) of ERISA, 29 U.S.C. § 1132(a). Pet. App. 13a. But the Seventh Circuit also correctly held that section 4-10 is enforceable in actions brought under section 502(a) of ERISA, citing this Court's decision in *UNUM*. Pet. App. at 21a-23a.

UNUM applies with equal force here. Under the Court's reasoning, the California notice-prejudice rule effectively created a mandatory contract term requiring insurers to prove prejudice before they denied coverage on the basis of an untimely claim. *UNUM*, 526 U.S. at 374. Section 4-10 also creates a mandatory contract term because it is actually incorporated into HMO coverage by operation of Illinois law. *See Plumb v. Fluid Pump Service, Inc.*, 124 F.3d 849, 861 (7th Cir. 1997). Furthermore, this Court rejected the contention in *UNUM* that ERISA preempted the notice-prejudice rule because the rule regulated only the administration of insurance policies and not the substantive policy terms. *UNUM*, 526 U.S. at 375, n.5. Thus, under *UNUM*, the fact that the mandatory contract term created by section 4-10 concerns procedural aspects of claims processing rather than substantive aspects of HMO coverage does not result in preemption.

After concluding in *UNUM* that the ERISA savings clause applied to California's notice-prejudice rule, the Court considered whether the rule was nonetheless

preempted because it conflicted with ERISA. The Court held that section 502(a) of ERISA did not preempt the notice-prejudice rule, noting that the plaintiff had brought suit under section 502(a). *UNUM*, 526 U.S. at 377. The Court concluded that the notice-prejudice rule "supplied the relevant rule of decision for this § 502(a) suit." *Id*. Here, too, Moran brought a claim under section 502(a) of ERISA in her second amended complaint after the district court denied her motion to remand to state court. JA 23. As the Seventh Circuit concluded, section 4-10 forms the relevant rule of decision in this case, just as the state-law rule did in *UNUM*.[9] Pet. App. at 23a. There is no conflict between section 4-10 of the Illinois HMO Act and section 502(a) of ERISA.[10]

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[9] Rush suggests in a footnote that there is a potential problem under Article III of the Constitution because the Seventh Circuit employed state law to resolve a federal claim brought under section 502(a) of ERISA. Pet. Br. at 25, n.6. But the situation here is the same as the one in *UNUM*; a state-law rule formed the relevant rule of decision in both instances. The cases cited by Rush do not hold that this scenario violates Article III.

[10] The *amici* supporting Rush contend that the Seventh Circuit's analysis is inconsistent with *Firestone Tire and Rubber Co v. Bruch*, 489 U.S. 101 (1989). *Amicus* brief of American Association of Health Plans, Inc., *et al*., p. 14. This Court held in *Bruch* that, when a benefit denial is challenged in an action brought under section 502(a) of ERISA, federal courts should apply a *de novo* standard of review unless the plan gives the administrator discretionary authority to determine eligibility for benefits. *Bruch*, 489 U.S. at 115. *Bruch* does not preclude states from enacting laws that effectively prevent HMOs and other insurers from writing policies that grant

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B. Section 4-10 Effectively Requires Binding Arbitration, Which Is Consistent With ERISA.

In arguing that section 502(a) of ERISA preempts section 4-10, Rush states that this independent external review provision effectively requires binding arbitration. Pet. Br. at 22, 31, n.10. Illinois agrees the dispute resolution procedure set forth in section 4-10 is similar to arbitration because section 4-10 provides for the selection of a person who will make a binding determination in a disputed matter, in this case the medical necessity of treatment proposed by an HMO enrollee's treating physician. *See Wauregan Mills, Inc. v. Textile Workers Union of America, AFL-CIO*, 21 Conn. Sup. 134, 146 A.2d 592, 595 (1958) (defining "arbitration"); *Black's Law Dictionary* 105 (6th ed. 1990).

This characterization of section 4-10 hardly helps Rush's cause. Under the Federal Arbitration Act, arbitration clauses in contracts involving commerce are "valid, irrevocable, and enforceable." 9 U.S.C. § 2. Thus, as this Court has recognized, there is a federal policy that favors arbitration. *Shearson/American Express, Inc. v. McMahon*, 482 U.S. 220, 227 (1987); *Moses H. Cone Mem. Hosp. v. Mercury Constr. Corp.*, 460 U.S. 1, 24 (1983).

In *McMahon*, the plaintiffs filed a complaint alleging that the defendants had violated the antifraud provisions in section 10(b) of the Securities and Exchange Act

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[10] (...continued)
them discretion in determining eligibility for benefits. And there is no conflict with ERISA in this context as ERISA does not set forth a standard of review of denials of benefits by a plan administrator.

of 1934, 15 U.S.C. § 78j(b), although the plaintiffs' agreement with the defendant brokerage firm required arbitration of such claims. *McMahon*, 482 U.S. at 223. The plaintiffs argued that the arbitration provision was invalid and relied on provisions of the Securities and Exchange Act granting federal district courts exclusive jurisdiction over violations of that act, 15 U.S.C. § 78aa, and declaring void any condition, stipulation, or provision compelling anyone to waive compliance with any of that Act's provisions, 15 U.S.C. §§ 78cc(a). Despite these provisions, this Court held that the agreement to arbitrate was valid. *Id.* at 227-38.

This Court has not considered whether mandatory arbitration agreements in ERISA plans are consistent with ERISA. Nevertheless, the *McMahon* decision and the federal policy favoring arbitration indicate that section 502(a) of ERISA does not operate as a bar to arbitration of claims for ERISA benefits. In fact, every federal circuit that has considered the issue has concluded that clauses in ERISA plans that require arbitration do not conflict with ERISA. *See Chappel v. Laboratory Corp. of Am.*, 232 F.3d 719, 724-25 (9th Cir. 2000); *Kramer v. Smith Barney*, 80 F.3d 1080, 1084 (5th Cir. 1996); *Pritzker v. Merrill Lynch, Pierce, Fenner & Smith*, 7 F.3d 1110, 1115-16 (3d Cir. 1993); *Bird v. Shearson Lehman/American Express, Inc.*, 926 F.2d 116, 122 (2d Cir. 1991), *cert. denied*, 501 U.S. 1251 (1991); *Graphics Communication Union v. GCIU-Employer Retirement Benefit Plan*, 917 F.2d 1184, 1188-89 (9th Cir. 1990) *Arnulfo P. Sulit, Inc. v. Dean Witter Reynolds*, 847 F.2d 475, 478-79 (8th Cir. 1988). Here, section 4-10 is consistent with ERISA's central purpose, which is protecting plan participants and their beneficiaries. *See* 29 U.S.C. § 1001(b). Section 4-10 protects HMO enrollees by enabling them to receive independent physician review when the enrollee's primary care physician and the HMO disagree about the medical necessity of treatment proposed by the primary care physician.

Rush argues that a different result is warranted here because the "arbitration" requirement set forth in section 4-10 is imposed by state law, and is not voluntarily undertaken by HMOs. Pet. Br. at 31 n.10. In making this argument, Rush ignores the rationale behind the Federal Arbitration Act and the its policy of encouraging arbitration. In enacting this statute, Congress recognized that arbitration is a desirable alternative to litigation in light of the complexities of litigation. *Scherk v. Alberto-Culver Corp.*, 417 U.S. 506, 511 (1974). The Federal Arbitration Act was intended to allow parties to avoid the expense and delays resulting from litigation and to place arbitration agreements on an equal footing with other types of contracts. *Id.* at 510-11. There is no reason why these policies should not apply with equal force in situations where state law dictates the terms of an agreement to arbitrate.

Here, the Illinois legislature has chosen to require HMOs to agree to independent physician review, a form of binding arbitration, when there is a dispute between an HMO and an enrollee's treating physician about the medical necessity of proposed treatment. 215 Ill. Comp. Stat. 125/4-10 (2000). In the course of regulating the business of insurance, states may dictate contract terms to insurers, and those terms become enforceable parts of agreements between the insurers and their insureds. *See UNUM*, 526 U.S. at 374-77; *Metropolitan Life*, 471 U.S. at 742-46. ERISA does not preclude Illinois from enforcing the independent physician review requirement of section 4-10.

C. Section 4-10 Of The HMO Act Does Not Conflict With ERISA's Requirement That Employee Benefit Plans Offer An Opportunity For Full And Fair Review Of A Claim Denial By The Appropriate Named Fiduciary.

Section 503 of ERISA states that, in accordance with regulations of the Secretary of Labor, an employee benefit plan must "afford a reasonable opportunity to any participant or beneficiary whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim." 29 U.S.C. § 1133(2). Section 4-10 does not purport to eliminate this requirement of internal fiduciary review in any manner. Instead, it merely adds the separate requirement of independent external review by a physician in the event of a conflict between the HMO and an enrollee's treating physician over the medical necessity of a covered service. This independent physician review only takes place after the "full and fair" fiduciary review required by section 503 of ERISA. Rush's argument that there is a conflict between section 4-10 of the HMO Act and section 503 of ERISA should therefore be rejected.

The primary purpose of ERISA's fiduciary provisions is "to insure against the possibility that the employee's expectation of the benefit would be defeated through poor management by the plan administrator." *Massachusetts v. Morash*, 490 U.S. 107, 115 (1989). The requirement of full and fair review by a fiduciary set forth in section 503 of ERISA furthers ERISA's goal of protecting plan participants and their beneficiaries. *See* 29 U.S.C. § 1001(b). Section 4-10 of the HMO Act furthers this goal as well. Like the notice-prejudice rule at issue in *UNUM*, section 4-10 "complements rather than contradicts ERISA" by providing additional protection to insured parties. *UNUM*, 526 U.S. at 377.

Rush argues that the independent physician review requirement of section 4-10 is inconsistent with section 503 of ERISA because the independent review is not conducted by a plan fiduciary, as required by section 503. Pet. Br. at 22, n.5. This argument is based upon the premise that the independent review requirement becomes part of the "full and fair review" required under section 503 of ERISA.

Rush's premise is faulty, as the Secretary of Labor recognized in regulatory amendments that will be effective on January 1, 2002. The amendments add several subsections to a regulation that applies to claims procedures and establishes requisites for the "full and fair" fiduciary review required by section 503 of adverse benefit determinations. *See* 65 Fed. Reg. 70,270. Under the new subsection (k)(2)(i) of this regulation, a state law regulating insurance that establishes a procedure to resolve disputes involving adverse benefit determinations will not be preempted by the regulation as long as the person who conducts the review is not the insurer, the plan, a plan fiduciary, the employer, or an agent of any of the same. 65 Fed. Reg. 70,270 (to be codified at 29 C.F.R. § 2560.530-1(k)(2)(i)). The new subsection (k)(ii) provides that state-law external review procedures of the type described in subsection (k)(i) "are not part of the full and fair review required by section 503" of ERISA. 65 Fed. Reg. 70,271 (to be codified at 29 C.F.R. § 2560.530-1(k)(ii)).

The Secretary of Labor's new regulations correctly recognize the distinction between the full and fair internal review required by section 503 of ERISA and the exter-

nal review required by state laws such as section 4-10 of the HMO Act. The new regulatory amendments also recognize that external review laws like section 4-10 are consistent with section 503 although the review is conducted by a person who is not a plan fiduciary. If accepted, Rush's contrary argument would mean that mandatory arbitration clauses in ERISA plans would violate section 503 because the arbitration would not be conducted by a plan fiduciary. Such a result would be inconsistent with the decisions cited above holding that mandatory arbitration clauses in ERISA plans do not conflict with ERISA.

In any event, medical necessity determinations involving ERISA plan beneficiaries need not be made by fiduciaries. *See Pegram v. Herdrich*, 530 U.S. 211 (2000). In *Pegram*, the Court stated that, when medical necessity is at issue, decisions about eligibility for coverage "cannot be untangled from physicians' judgments about reasonable medical treatment." *Id.* at 229. The Court went on to hold that these "mixed eligibility" decisions were not fiduciary acts, and Congress did not intend that any HMO be treated as a fiduciary to the extent that the HMO makes such decisions through its physicians. *Id.* at 229-37. Thus, section 4-10 of the HMO Act does not conflict with ERISA to the extent that it allows independent reviewing physicians who are not acting as fiduciaries to make medical necessity determinations under certain circumstances.

Rush contends that, if ERISA does not preempt section 4-10 and similar laws, plan administrators will be subject to a "patchwork scheme of regulation." Pet. Br. at 29. As the Court has recognized, however, Congress' decision to save from preemption state laws that regu-

late insurance inevitably causes some lack of uniformity in plan administration. *Metropolitan Life*, 471 U.S. at 747. Congress nevertheless chose to allow states to regulate plans indirectly by regulating their insurers directly, *FMC Corp.*, 498 U.S. at 64, as Illinois has done here by enacting section 4-10 of the HMO Act. Section 4-10 is not preempted by ERISA because it is a law that regulates insurance, and it does not conflict with section 502(a) or any other provision of ERISA. To the contrary, this is a case where the state law at issue furthers ERISA's goal of protecting plan beneficiaries and participants. 29 U.S.C. § 1001(b); *Morash*, 490 U.S. at 115 (1989). Section 4-10 "complements rather than contradicts ERISA" and it is saved from preemption by ERISA's savings clause. *See UNUM*, 526 U.S. at 377.

D. Under The Plain Language Of The Savings Clause, Section 4-10 Of The Illinois HMO Act Is Saved From Preemption Even If It Conflicts With One Of ERISA's Other Provisions.

As Illinois has argued above, ERISA's savings clause applies and excepts section 4-10 of the HMO Act from preemption because the provision is a state law regulating insurance and because it does not conflict with any provisions of ERISA. If this Court reaches a contrary conclusion, however, it should nonetheless hold that section 4-10 is not preempted. Under the plain language of the savings clause, the clause would still apply and save section 4-10 from preemption.

The Court indicated in *Pilot Life* that a state law that regulates insurance is still preempted if the law conflicts with a substantive provision of ERISA. 481 U.S. at 54-57. In reaching this conclusion, the Court relied largely

on the legislative history of ERISA. This aspect of *Pilot Life* was not necessary to the Court's holding because the Mississippi common-law rule at issue in that case did not regulate insurance, so the savings clause did not apply to it. *Id.* at 50.

The Court's reliance on ERISA's legislative history was misplaced in light of the language of the savings clause, which states that nothing in the ERISA preemption provision "shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." 29 U.S.C. § 1144(b)(2)(A). The savings clause unambiguously exempts state laws regulating insurance like section 4-10 from ERISA preemption without exception. When a statute is unambiguous, the judicial inquiry about its meaning is at an end, and the provision should be enforced as written. *Connecticut Nat'l Bank v. Germain*, 503 U.S. 249, 254 (1992). Therefore, there was no need to consult the legislative history of ERISA in order to ascertain the scope of the savings clause.

Furthermore, the portion of ERISA's legislative history that the Court relied on in *Pilot Life* contains a flawed analogy between ERISA and the federal Labor-Management Relations Act ("LMRA"). The LMRA does not have any statutory exception to preemption similar to ERISA's savings clause, thereby undermining the validity of any analogy between the two statutes.[11] Relying

[11] The Solicitor General of the United States pointed this out in a brief filed in *UNUM*. *UNUM*, 526 U.S. at 376, n.7. The Solicitor General went on to argue in the brief that the ERISA savings clause on its face saves state laws regulating
(continued...)

on this flawed analogy, the Court concluded that section 502(a) of ERISA was intended to have the same preemptive force as section 301 of the LMRA, 29 U.S.C. § 185, which completely displaces any state-law cause of action for the violation of a collective bargaining agreement between a labor organization and an employer, thereby reflecting Congress' intent that federal labor law uniformly prevail over state and local rules. *Pilot Life*, 481 U.S. at 55-56.

Since *Pilot Life*, the Court has emphasized that a presumption exists that ERISA does not preempt state law when the state is exercising its historic police powers. *New York Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995). States have traditionally regulated the business of insurance, as Congress recognized when it enacted the McCarran-Ferguson Act, an act that says federal antitrust laws apply to the business of insurance only to the extent that this business is not regulated by state law, 15 U.S.C. § 1012, and when it enacted ERISA's savings clause, 29 U.S.C. § 1144(b)(2)(A). Remedial provisions designed to address violations are an important aspect of state insurance laws. The savings clause expresses the intent of Congress to avoid interference with the States' power to regulate insurance. *See Metropolitan Life*, 471 U.S. at 740-41. If it is necessary to decide the issue, the Court should hold that the ERISA savings clause saves from preemption state laws that provide remedies. Such a holding would vindicate the states'

[11] (...continued)
insurance that create remedies or causes of action. *Id.* (acknowledging the Solicitor General's argument, but stating that it need not be addressed).

authority to regulate insurance, an authority that Congress expressly sought to preserve when it enacted the savings clause.

CONCLUSION

The judgment of the United States Court of Appeals for the Seventh Circuit should be affirmed.

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IN THE

Supreme Court of the United States

RUSH PRUDENTIAL HMO, INC., *Petitioner*,

RECEIVE

v.

DEBRA C. MORAN AND STATE OF ILLINOIS, *Respondents.*

On Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

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IN THE

Supreme Court of the United States

No. 00-1021

RUSH PRUDENTIAL HMO, INC.,
Petitioner,

v.

DEBRA C. MORAN AND STATE OF ILLINOIS,
Respondents.

REPLY BRIEF FOR PETITIONER

The briefing highlights the fact that this case brings the Court to a crossroads in its ERISA preemption jurisprudence. The path we urge the Court to take begins with a recognition that this Court meant what it said in *Pilot Life Insurance Co.* v. *Dedeaux*, 481 U.S. 41, 52, 57 (1987), when it ruled that Congress intended "ERISA's civil enforcement scheme [to] be exclusive" and to preempt state-law "remedies for the improper processing of a claim for benefits under an ERISA-regulated plan." It requires only the conclusion that a state law allowing beneficiaries dissatisfied with their ERISA plan's benefits determination to secure a ruling from a different decisionmaker overturning that determination is in fact a "remed[y] for the improper processing of a claim for benefits." That path offers the advantages of consistency and a clear and simple rule that the circuit courts can appreciate and follow. If Congress disagrees with it, Congress can change it—something Congress has not chosen to do in the fourteen years since *Pilot Life*.

Respondents and their amici would have the Court go down a different route, although there are as many different and contradictory maps of that route as there are bottom-side briefs. The Federal Government's position *du jour*, for example, is that this Court in *Pilot Life* meant only that state *court* remedies were preempted (though the Solicitor General does not explain why anyone would have thought such a system made sense), and that alternative state-law remedies for ERISA benefits, such as Section 4-10, are acceptable so long as they are enforced in an ERISA action—under what, if any, standard of review being left deliberately vague. *See* U.S. Br. 26-27 & n.13. Other independent review schemes would be preempted if the reviewer's decision were enforced in state court, if the reviewer could assess punitive damages, or if beneficiaries (as opposed to the plan) could be forced to undergo the review.

However self-assured the Federal Government might be about the ultimate wisdom of this latest refinement of its position, no one can seriously suggest that its various caveats, provisos, assumptions, and unresolved issues furnish a useful or usable guide for the circuit courts confronted with the next ERISA preemption issue—or even a meaningful test for deciding whether any of the other 39 state independent review laws, each with its particular features, passes muster. Adopting such an approach simply guarantees that the circuit courts will continue to reach conflicting results at an alarming rate. The Court should not muddy further its ERISA preemption jurisprudence with such a preciously refined analysis. It should instead dare to paint with primary colors in this case, hold that it meant what it said in *Pilot Life*, and that the remedy provided by Section 4-10 is therefore preempted.

I. SECTION 4-10 CONFLICTS WITH ERISA'S EXCLUSIVE REMEDIAL SCHEME

ERISA provides a remedy for beneficiaries dissatisfied with a plan's determination of benefits: an action under

Section 502(a), 29 U.S.C. § 1132(a), in which the court examines whether the plan fiduciary abused the discretion granted it under the plan. *See Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101, 111 (1989). The remedy chosen by Moran, in contrast, consists of state-compelled, binding independent review under Section 4-10, in which an independent physician determines, apparently de novo, whether a benefit is covered. Section 4-10 directs that Rush "shall provide" the service if the reviewer determines that it is covered. That remedy squarely conflicts with Congress' intent, recognized in *Pilot Life*, that ERISA's remedies are *exclusive* and that state laws that supplement or supplant those remedies are preempted.

Respondents and their amici maintain that the alternative remedy chosen by Moran does not conflict with ERISA's exclusive remedies, for three principal reasons. First, they argue that because parties could voluntarily agree to internal review procedures resembling Section 4-10, States can compel such procedures. Second, they argue that Section 4-10 is not really an alternative remedy at all because it is not, at least in the first instance, a judicial remedy. Third, they argue that the Section 4-10 remedy is not preempted because it provides only the relief available under ERISA, and no more. None of these arguments withstands scrutiny.

A. Section 4-10 Is Preempted Regardless Of Whether A Plan Could Voluntarily Agree To Arbitration As Part Of The Plan's Internal Review

Respondents and their amici contend that ERISA permits plans to adopt arbitration procedures as part of their internal benefit determination processes. Therefore, they argue, Section 4-10 must not conflict with ERISA either. *See, e.g.*, Moran Br. 35; U.S. Br. 29; Illinois Br. 29-31; NAIC Br. 17-18; AMA Br. 22-23.

But whether parties to an ERISA plan may voluntarily agree to arbitration as part of the plan's internal procedures

says nothing about whether state laws can *compel* additional or alternative *external* remedies for beneficiaries seeking to challenge benefits determinations. Respondents and their amici cite no preemption precedent suggesting that this consideration is at all pertinent to the analysis, and it plainly is not. For example, nothing prevented employers in *Gade* v. *National Solid Waste Management Ass'n*, 505 U.S. 88 (1992), from voluntarily requiring that their employees log 500 days of training, but that did not save a state law imposing the same requirement from preemption. Nothing prevented manufacturers in *Geier* v. *American Honda Motor Co.*, 529 U.S. 861 (2000), from voluntarily installing airbags in their automobiles in 1984, but that did not save state law imposing the same safety standard from preemption. Likewise, ERISA is regularly found to preempt state laws imposing requirements that plans are perfectly free to adopt voluntarily.[1]

ERISA's principal purpose is to allow administrators of nationwide plans "to establish a uniform administrative scheme" with "a set of standard procedures to guide processing of claims and disbursement of benefits," free from the specter of fifty different state laws. *Egelhoff*, 121 S. Ct. at 1328 (quotation omitted). That purpose is served by permitting parties to a plan to adopt voluntary and uniform benefit determination procedures. It is not served if each and every State can impose its own remedy for beneficiaries dissatisfied with the plan's determinations.

For the same reason, Moran's contention that Section 4-10 does not conflict with ERISA's internal review requirements,

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[1] *See, e.g.*, *Egelhoff* v. *Egelhoff*, 121 S. Ct. 1322 (2001) (state statute mandating particular beneficiary designation preempted); *District of Columbia* v. *Greater Washington Bd. of Trade*, 506 U.S. 125 (1992) (state law requiring employers to provide particular level of health insurance for injured employees eligible for workers' compensation preempted).

Br. 35-40, is beside the point. Section 4-10 is not a different way for the plan to reach its own internal decision; it is an external means through which a beneficiary can challenge that decision. That conflicts with Congress' intent that an action under Section 502(a) be the exclusive means of reviewing plan determinations. *Pilot Life*, 481 U.S. at 52, 57.

The Solicitor General and other amici rely on an analogy to Section 301 of the Labor Management Relations Act ("LMRA"), 29 U.S.C. § 185, which, as the Court has noted, was a model for ERISA's preemptive scope. *See* U.S. Br. 23, 28; AMA Br. 22; NAIC Br. 17. The analogy hurts their cause. The Solicitor General observes that the LMRA encourages private arbitration agreements as the means of resolving disputes under collective bargaining agreements ("CBAs"). From this, he concludes that Section 4-10 must be permissible under ERISA because it simply establishes a type of arbitration. *See* U.S. Br. 28. His premise is wrong. The LMRA has no preference for arbitration *per se*; it embodies a preference for resolving disputes under CBAs *in the manner agreed to by the parties*.[2] Purely voluntary

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[2] *See, e.g.*, *United Steelworkers of Am.* v. *American Mfg. Co.*, 363 U.S. 564, 566 (1960) (policy of LMRA "can be effectuated only if the means chosen by the parties for settlement of their differences under a collective bargaining agreement is given full play"); *United Steelworkers of Am.* v. *Warrior & Gulf Nav. Co.*, 363 U.S. 574, 581 (1960) ("[An arbitrator] is not a public tribunal imposed upon the parties by superior authority which the parties are obliged to accept. * * * He is rather part of a system of self-government created by and confined to the parties.") (quotation omitted); *Graphic Communications Int'l Union, Local 735-S* v. *North Am. Directory Corp. II*, 98 F.3d 97, 101 n.5 (3d Cir. 1996) ("It is not arbitration per se that federal policy favors, but rather final adjustment of differences by a means selected by the parties.") (quotation omitted); 29 U.S.C. § 173(d) ("Final adjustment by a method *agreed upon by the parties* is declared to be the desirable method for settlement of grievance disputes arising over

agreements to arbitrate are consistent with that policy. But a state law imposing a particular arbitral remedy *not* agreed to by the parties conflicts with the central policies of the LMRA. It is not surprising, then, that the LMRA preempts state proceedings involving interpretation of CBAs, even where the state remedies are non-judicial. *See, e.g., Carver Lumber Co.* v. *Illinois Human Rights Comm'n*, 515 N.E.2d 417 (Ill. App. Ct. 1987) (LMRA preempted state administrative proceeding). The LMRA would likewise preempt a state law compelling independent review of a provision of a CBA in a manner contrary to the CBA. The same is true under ERISA.

Moreover, Section 4-10, while similar to arbitration, is quite different from the form typically found in voluntary agreements. Section 4-10 is binding on HMOs once it is invoked, but unlike arbitration agreements, beneficiaries are not obligated to invoke the Section 4-10 remedy. They may elect to pursue ERISA remedies instead. And, under respondents' theory, they would even be entitled to two bites at the apple: if a claim is denied by the Section 4-10 reviewer, a beneficiary could file an ERISA action seeking the same benefits. That is nothing like a voluntary arbitration procedure, but is instead an alternative remedy mandated by state law.

Recognizing this one-sided process, the Solicitor General notes that under Department of Labor regulations " 'claimants cannot be required to submit their claims to [state law external review] procedures in order to be entitled to file suit under the Act.' " U.S. Br. 22 (quoting 65 Fed. Reg. 70,254) (Nov. 21, 2000). *See also* 29 C.F.R. § 2560.503-1(k)(2)(i)-(ii). Thus, the Federal Government understands that ERISA would preempt state laws requiring *beneficiaries* to undergo external review, presumably because such laws—even

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the application or interpretation of an existing collective-bargaining agreement.") (emphasis added).

though resembling arbitration—would conflict with ERISA's exclusive remedies. The same must be true of Section 4-10, which mandates that plan administrators undergo the same kind of procedure.[3] The state law seeks to supplant or supplement ERISA's exclusive remedies in both cases, and is therefore preempted.

Deeming Section 4-10 to be part of the plan's internal decisionmaking also conflicts with ERISA's fiduciary requirements. *See* Pet. Br. 22-23 n.5. An independent reviewer is neither a plan fiduciary under Section 503 of ERISA, *see* 29 U.S.C. § 1133(2), nor someone the plan fiduciary has delegated to carry out plan functions. *See id.* § 1105(c)(1)(B); Illinois Br. 34. As the Solicitor General notes, under ERISA "the decisionmaker's fiduciary duty is to be faithful to the terms of the plan." U.S. Br. 9 n.4. This ensures that administrators give proper consideration to plan terms, and prevents them from giving unwarranted benefits to some beneficiaries in a way that jeopardizes coverage for others. Under ERISA, the fiduciary's decision is reviewed to determine whether the fiduciary abused the discretion the plan entrusted to it. Under Section 4-10, by contrast, a binding decision is made by an independent reviewer without any fiduciary obligation to the plan. *See* AMA Br. 3.

The Solicitor General responds that independent review laws do not conflict with ERISA's fiduciary requirements because "Section 503 * * * governs internal plan appeals, not external review." U.S. Br. 24-25 n.12. He cannot have it both ways. If Section 4-10 is an external remedy and therefore ungoverned by Section 503's fiduciary requirements, it is preempted under *Pilot Life*. If it is an internal remedy—

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[3] It is no answer to say that Section 502 confers rights of action only on beneficiaries, not plans. *See* U.S. Br. 23. Section 502(a)(3)(B) authorizes suits by plan fiduciaries to "enforce * * * the terms of the plan." 29 U.S.C. § 1132(a)(3)(B)(ii).

which it plainly is not—such a state-imposed remedy conflicts with the fiduciary requirements of Section 503.

B. ERISA Preempts All Alternative Or Additional State Law Remedies, Not Just Judicial Remedies

Respondents and their amici argue that Section 4-10 is not preempted under *Pilot Life* and its progeny, because the remedy provided by Section 4-10 is not (at least in the first instance) a judicial one. There is no conflict with ERISA's exclusive remedies, they say, because the results of the Section 4-10 proceeding can be enforced in an ERISA action, in which the only role for the court is to require the payment of benefits as the independent reviewer has decreed. Under their theory, then, a State can mandate *any* alternative remedy for reviewing a plan's benefit determinations, so long as final enforcement of the decision is through a rubber-stamp ERISA action. In their view and that of the Seventh Circuit, the Section 4-10 remedy is simply a term of the plan, and there is no conflict with ERISA's exclusive remedies because relief awarded by the Section 4-10 reviewer must still be enforced through an ERISA action. They are mistaken. Section 4-10 is as much an alternative remedy as any judicial action, and it should be treated no differently under ERISA.

The only pertinent difference between Section 4-10 and a judicial remedy is that the decisionmaker under Section 4-10 is a physician, while the decisionmaker in a judicial action is a judge or jury. But arbitration is still a remedy, even if an arbitrator's decision must be enforced through a subsequent judicial action. *See* Pet. Br. 31-32 n.10. Respondents do not refute that point. Nor could they, given this Court's repeated references to the "remedy" of arbitration.[4]

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[4] *See, e.g.*, *Air Line Pilots Ass'n* v. *Miller*, 523 U.S. 866, 876, 880 (1998) (referring to "arbitral remedy" and "arbitration remedy"); *DelCostello* v. *International Bhd. of Teamsters*, 462 U.S. 151, 163 (1983) (referring to "arbitration remedies"); *Great Am. Fed. Sav. & Loan Ass'n* v. *Novotny*, 442 U.S. 366, 377-378 (1979) (arbitration and litigation are "alternative remedies").

Respondents' argument also proves too much. It would allow States to circumvent ERISA preemption simply by deeming alternative remedies to be "plan terms" enforceable through an ERISA action. For example, a State could require plans to include procedures under which claims for benefits would be determined by a panel of twelve citizens selected from the voter rolls (*i.e.*, a jury), or by a person holding the qualifications of a state court judge, or by an administrative tribunal. Under the theory that ERISA's exclusive remedies preempt only coercive judicial enforcement mechanisms, *see, e.g.*, U.S. Br. 23; NAIC Br. 13, a State could even require plans to abide by state court declaratory judgments awarding benefits, provided the actual enforcement of those decisions is through an ERISA action. In respondents' view, none of these state laws would conflict with ERISA's exclusive remedies, because the outcome of each proceeding would be enforced through a rubber-stamp ERISA action.

Permitting such legerdemain would nullify ERISA's exclusive remedies. The uniformity of those remedies—"one of the essential tools for accomplishing the stated purposes of ERISA," *Ingersoll-Rand Co.* v. *McClendon*, 498 U.S. 133, 137 (1990) (quotation omitted)—would be destroyed if a State could mandate additional or alternative remedies simply by calling them plan terms. Respondents hardly address this argument. For example, they do not attempt to explain why, under their theory, ERISA would preempt state laws mandating juries or other external decisionmakers as incorporated plan terms, but not state laws mandating physician decisionmakers. Nor do they explain why, under their theory, ERISA would preempt a statute allowing an independent reviewer to award punitive damages or other relief not available in an ERISA action.[5] ERISA preempts all such

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[5] The Solicitor General responds only that States could not impose terms requiring plans to abide by punitive damages

laws for the same reason it preempts Section 4-10: such additional or alternative remedies interfere with ERISA's exclusive remedies.

Moreover, the rubber-stamp role to which respondents would relegate the federal courts in this case would raise profound concerns under Article III, because there is no federal law to apply or develop in the purportedly federal action to enforce the independent reviewer's decision. *See* Pet. Br. 25-26 n.6. The Solicitor General's rebuttal is unresponsive: he simply analogizes to the development of federal common law concerning arbitral decisions under the LMRA. U.S. Br. 23-24 n.11. His citation to *Textile Workers Union* v. *Lincoln Mills*, 353 U.S. 448 (1957), shows how far afield his analogy is. The referenced page of *Lincoln Mills* notes that federal courts may adopt compatible state law, but that "[a]ny state law applied * * * will be absorbed as federal law and will not be an independent source of private right[s]." *Id.* at 457. Here, state law provides the binding remedy being implemented in the federal court action under Section 502(a); the Seventh Circuit did not suggest that it was "absorbing" the Illinois independent review regime as federal law.

Illinois' reliance on *UNUM Life Ins. Co. of Am.* v. *Ward*, 526 U.S. 358 (1999), *see* Illinois Br. 27-28, 28 n.9, is likewise misplaced. This is not a case, as in *UNUM*, where state law supplies one of the relevant rules of decision in an action otherwise governed by federal law. *See* Pet. Br. 30-31.

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determinations "because private parties could not meaningfully contract for such a cause of action." U.S. Br. 20. That is not true: under Illinois law, arbitrators may award punitive damages if the parties have so agreed. *7-Eleven, Inc.* v. *Dar*, 757 N.E.2d 515, 523 (Ill. App. Ct. 2001); *Edward Elec. Co.* v. *Automation, Inc.*, 593 N.E.2d 833, 843 (Ill. App. Ct. 1992), *appeal denied*, 602 N.E.2d 450 (Ill. 1992). And even if its common law were otherwise, a State could override such restrictions by statute.

There is *no* function for federal courts at all under Section 4-10, other than to rubber-stamp a decision reached by a state-mandated decisionmaker applying a state statute. That is in fact what the court below did in this case. *See* Pet. App. 24a.[6]

C. ERISA Preempts Alternative State Law Remedies, Not Just Those Seeking Additional Relief

Illinois argues that Section 4-10 does not conflict with ERISA's exclusive remedies because Moran seeks only recovery of benefits—relief that would otherwise be available under ERISA. *See* Illinois Br. 26; *see also* U.S. Br. 21; State Amici Br. 23-24; AMA Br. 21. That argument is foreclosed by *Metropolitan Life Ins. Co.* v. *Taylor*, 481 U.S. 58 (1987), which held that ERISA preempts even those state law claims, like breach of contract claims, that seek relief also available under ERISA. The Court held in *Taylor* that a claim seeking "compensatory damages for money contractually owed Plaintiff" under a disability benefits plan was not only preempted, but so completely preempted as to permit removal to federal court. *Id.* at 61, 62-67. As the Court noted the same day in *Pilot Life*, ERISA preempts state laws that either "supplement[ ] *or* supplant[ ]" ERISA's exclusive remedies. 481 U.S. at 56 (emphasis added). Thus, the lower courts have uniformly held that ERISA preempts state law

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[6] Moran argues that a federal court "will have the same function it always had under [Section 502(a)]." Br. 39-40 n.18. But there is a world of difference between a federal court construing a document under developing standards of federal common law (including standards of review) and a federal court merely enforcing a state law providing that an HMO "*shall* provide the covered service" if an independent reviewer decides that the service is medically necessary. 215 Ill. Comp. Stat. 125/4-10 (emphasis added).

contract actions even if those actions seek the same recovery available under ERISA.[7]

The reason is clear: even if an alternative remedy provides the same relief as an ERISA action, allowing each State to impose its own such remedy, with differing standards and decisionmakers, is "fundamentally at odds with the goal of uniformity that Congress sought to implement." *Ingersoll-Rand*, 498 U.S. at 142.[8]

II. SECTION 4-10 IS NOT SAVED BY ERISA'S SAVING CLAUSE

A. Under *Pilot Life*, Laws That Conflict With ERISA's Exclusive Remedies Do Not Fall Within ERISA's Saving Clause

The central holding of *Pilot Life* is that state laws seeking to supplement or supplant ERISA remedies are necessarily preempted, regardless of whether such laws would otherwise fall within ERISA's saving clause. Thus, because Section 4-10 conflicts with ERISA's exclusive remedies, there is no need for the Court even to consider the other tests to determine if it is within the saving clause. *See* Pet. Br. 32-36.

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[7] *See, e.g.*, *Bowles* v. *Quantum Chem. Co.*, 266 F.3d 622, 631 (7th Cir. 2001); *Aetna Life Ins. Co.* v. *Bayona*, 223 F.3d 1030, 1034 (9th Cir. 2000); *Kolasinski* v. *Cigna Healthplan of CT, Inc.*, 163 F.3d 148, 149 (2d Cir. 1998); *Board of Trustees of Hotel & Rest. Employees Local 25* v. *Madison Hotel, Inc.*, 97 F.3d 1479, 1486-87 (D.C. Cir. 1996).

[8] In addition, it is not correct to regard the remedy provided by Section 4-10 as merely duplicative of ERISA remedies. *See* Pet. App. 25a-26a (Section 4-10 "establishes a system of appellate review of benefits decisions that is distinct from the provision in ERISA for suits in federal court to enforce entitlements conferred by ERISA plans. * * * The suit for breach of contract envisaged by the statute becomes a suit for judicial review of the independent physician's decision.") (Posner, J., dissenting from denial of rehearing en banc).

Illinois, however, contends that this central holding was dicta. *See* Illinois Br. 35-36; *see also* NAIC Br. 20. That argument is untenable. *Pilot Life* held that the state law remedies at issue there were not within the scope of the saving clause, and were therefore preempted. *Pilot Life*, 481 U.S. at 57 (concluding that state law claim was "not saved by § 514(b)(2)(A), and is therefore preempted by § 514(a)"). According to the Court, the "most important[ ]" factor leading to that result was "the clear expression of Congressional intent that ERISA's civil enforcement scheme be exclusive." *Id.* Thus, the Court's recognition that ERISA's remedies are exclusive was the "most important" part of its holding that additional or alternative remedies are not within the scope of the saving clause, and are therefore preempted. That is not dicta.

This fact also disposes of the argument that *Pilot Life* is somehow inconsistent with the language of the saving clause. *See, e.g.*, NAIC Br. 22-24; United Policyholders Br. 10. The Court did not hold that laws that fall within the terms of the saving clause are nevertheless preempted when they seek to supplement or supplant ERISA's exclusive remedies. Rather, the Court held that a law that seeks to supplement or supplant ERISA's exclusive remedies does not fall within the terms of the saving clause at all, because such a law does not "regulate[ ] insurance." 29 U.S.C. § 1144(b)(2)(A). Rather than regulate insurance—a subject ERISA does not address—such a law regulates the procedural remedies for enforcing rights under ERISA plans, a subject reserved exclusively to ERISA and the federal common law developed under it. *Cf.* U.S. Br. 4 (recognizing that claims processing is a "core concern" of ERISA). In fact, as shown below, *infra* at 14-18, Section 4-10 does not even regulate insurance within the meaning of the other saving clause factors.

That *Pilot Life* controls this case is demonstrated by the fact that several of respondents' amici urge the Court to overrule that decision. *See* United Policyholders Br. 28;

AARP Br. 23-28; California Consumer Br. 6. We have shown why there is no cause for the Court to do so. *See* Pet. Br. 34-35. ERISA preemption law is already confused enough, as evidenced by the twenty cases already decided by the Court and the four more (at least) awaiting action on the Court's docket,[9] not to mention the twists and turns of the various positions of the United States.[10] Extinguishing one of the few beacons of clarity in this area would exponentially exacerbate the confusion in the law.

B. The Other Saving Clause Factors Demonstrate That Section 4-10 Does Not Regulate Insurance

1. Even if the Court were to consider the other saving clause factors, those factors likewise demonstrate that Section 4-10 does not fall within the insurance saving clause. The first of these factors should also be the most straightforward: common sense. *See UNUM*, 526 U.S. at 367. In order for the common-sense inquiry to have any significance independent of the three McCarran-Ferguson guideposts, however, it must operate as something more than a free-wheeling judgment about whether the challenged law "regulates insurance." It should function as an inquiry into whether the state law at issue has historically been regarded as a type of insurance regulation reserved to the States.

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[9] *See United States Healthcare Sys. of Pa., Inc.* v. *Pennsylvania Hosp. Ins. Co.*, No. 01-200; *Kentucky Ass'n of Health Plans, Inc.* v. *Miller*, No. 00-1471; *Community Health Partners, Inc.* v. *Kentucky*, No. 00-1295; *Montemayor* v. *Corporate Health Ins., Inc.*, No. 00-665.

[10] *Compare* U.S. Br. 28-29 n.14 *with* U.S. Br. 22-23 & n.12, 24 n.13, 25 & n.14, *UNUM Life Ins. Co.* v. *Ward*, No. 97-1868 (filed Dec. 2, 1998) *and* U.S. Br. 18-19, *Pilot Life Ins. Co.* v. *Dedeaux*, No. 85-1043 (filed May 30, 1986); *see also* Pet. Supp. Br. 1-2, *United States Healthcare Sys. of Pa., Inc.* v. *Pennsylvania Hosp. Ins. Co.*, No. 01-200 (filed Nov. 19, 2001) (noting three different positions taken by United States in that case).

Thus, for example, in *Metropolitan Life Insurance Co.* v. *Massachusetts*, 471 U.S. 724, 742-743 (1985), the Court upheld the mandated-benefit law at issue in large part on the ground that it had historically been regarded as a traditional insurance law.

Section 4-10, in contrast, is directed specifically at HMOs, which have historically been regarded by States as distinct from indemnity insurance providers.[11] Illinois itself provides that only a select set of Insurance Code provisions are applicable to state-certified HMOs, which are organized not under the Insurance Code, but under the Business Corporation Act. *See* 215 Ill. Stat. 125/5-3(a). And some HMOs, as we observed in our opening brief, may neither offer insurance products nor bear the risk for the health plans with which they contract. A law that is not specifically directed at risk-bearing entities, and that does not accomplish any risk spreading or transfer, does not regulate a business traditionally defined at its core essence as the shifting of risk.

2. Indeed, the first McCarran-Ferguson factor, the spreading or transfer of risk, is an "indispensable characteristic" of the business of insurance. *Group Life & Health Ins. Co.* v. *Royal Drug Co.*, 440 U.S. 205, 212 (1979). An insurance regulation spreads risk by allocating it among a large pool of insureds; the mandated-benefits law at issue in *Metropolitan Life* v. *Massachusetts*, for example, spread risk by distribut-

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[11] *See, e.g.*, Cal. Ins. Code § 740(g) ("A health care service plan [*i.e.*, HMO] * * * shall not be subject to this section."); Fla. Stat. § 641.30(2) ("Except as provided in this part, the Florida Insurance Code does not apply to [HMOs] certificated under this part"); Va. Code § 38.2-4319(a) (stating that only enumerated provisions of the state insurance code apply to HMOs); N.J. Stat. 26:2J-25a ("Except as otherwise provided in this act, provisions of the insurance law * * * shall not be applicable to any [HMO] granted a certificate of authority under this act."); Md. Health-Gen. Code § 19-706(c) ("Except as otherwise provided in this subtitle, [an HMO] is not subject to the insurance laws of this State.").

ing treatment costs for a small but high-risk pool of insureds among a far larger number of policyholders. 471 U.S. at 731, 743. And as this Court explained in *Union Labor Life Ins. Co.* v. *Pireno*, 458 U.S. 119, 130-131 (1982), risk transfer—the shifting of risk from one party to another—occurs when the parties enter into an insurance contract, because the policy defines "the measure of the risk that has actually been transferred to the insurer." *Id.* at 130.

The Seventh and Fifth Circuits largely conceded that independent review provisions like Section 4-10 do not spread or transfer risk. *See* Pet. Br. 40 n.16. Independent review laws do not spread risk because they do not mandate that a class or type of benefits be disbursed to all policyholders. Nor do such laws affect risk allocation between parties at the time they enter into an insurance agreement; such laws are "logically and temporally unconnected to the transfer of risk." *Pireno*, 458 U.S. at 130. Moran argues that Section 4-10 may, in certain instances, shift costs to an HMO if its medical necessity decision is overridden. Moran Br. 26. But so do ERISA's remedies, Pet Br. 41 n.17, and so do all state laws that place financial burdens on HMOs. That does not suffice to transform the state law into one that "spreads risk."

3. Section 4-10 is not an "integral part of the policy relationship"—the next McCarran-Ferguson factor—because the law does not "define the terms of the relationship" between insurer and insured. *Metropolitan Life* v. *Massachusetts*, 471 U.S. at 743; *Pilot Life*, 481 U.S. at 51. Section 4-10 does not "change the bargain between insurer and insured," like the law at issue in *UNUM*, 526 U.S. at 374. The terms of the bargain remain the same. The law simply supplies an alternative mechanism by which plan beneficiaries can enforce the plan's terms. That is why, under *Pilot Life*, it is preempted.

4. Nor does Section 4-10 satisfy the final McCarran-Ferguson factor—whether the law is "limited to entities

within the insurance industry." *UNUM*, 526 U.S. at 375. Section 4-10 applies to HMOs regardless of whether they act as insurers or as administrators for other risk-bearing groups. *See Insurance Bd. of Bethlehem Steel Corp.* v. *Muir*, 819 F.2d 408, 412 (3d Cir. 1987) (law impacting Blue Cross & Blue Shield acting as a plan administrator did not satisfy third McCarran-Ferguson factor, because administrator was an "entit[y] outside the industry").

The Solicitor General contends that even HMOs performing administrative functions still bear risk in some distant sense, because those functions may be "associated with the risk-bearing function." Br. 15. But performing tasks "associated with" risk-bearing is not nearly the same as actually bearing risk. *See Powell* v. *Chesapeake & Potomac Tel. Co. of Va.*, 780 F.2d 419, 423 (4th Cir. 1985) (insurance company acting as plan administrator "neither spreads nor underwrites insurance risks; * * * [it] provides certain purely administrative claims processing functions"), *cert. denied*, 476 U.S. 1170 (1986).

The Solicitor General, joined by Illinois, also suggests more boldly that HMOs which do not bear risk necessarily "retain an insurance function" because the claims processing services they perform are "inextricably intertwined with insurance and the bearing of risk." U.S. Br. 15; *see* Illinois Br. 18. Surely not. A business performing outsourced claims processing services for a traditional insurer does not become an "insurer" just because it pushes paper for the insurance company. *See Insurance Bd. of Bethlehem Steel Corp.*, 819 F.2d at 413 (company that processed claims and paid benefits for corporate benefit plan was not engaged in the "business of insurance"); *Powell*, 780 F.2d at 423.

Respondents are left with the unsatisfying argument that Section 4-10 actually applies to HMOs "only when they are acting as insurers." Illinois Br. 21; *see* Moran Br. 22; Pet. App. 17a. That is not what the law says. It applies to *all*

HMOs, including those that shift risk to their providers and those that manage health plans for other entities. Those HMOs may be health care administrators, or there may be some other name for the function they serve; but they are not insurers. Because Section 4-10 applies with equal force to entities outside the insurance industry, it does not satisfy the third McCarran-Ferguson factor.

III. SECTION 4-10 CONCEDEDLY RELATES TO ERISA PLANS

The above discussion demonstrates that Section 4-10—which provides an alternative remedy to recover benefits under an employer-sponsored health plan—falls within ERISA's broad preemption provision because it "relates to" ERISA plans. As the Seventh Circuit held, Section 4-10 relates to ERISA plans "because its provisions have a connection with such plans." Pet. App. 15a-16a; *see Ingersoll-Rand*, 498 U.S. at 139. Illinois concedes the point, Br. 13, as does the Solicitor General. U.S. Br. 6-7.

Respondent Moran's lead-off argument, however, is that Section 4-10 does not "relate to" ERISA plans. *See* Br. 16-21. She waived this argument by failing to raise it below. *TRW, Inc.* v. *Andrews*, 122 S. Ct. 441, 450-451 (2001). Indeed, in the Court of Appeals, Moran conceded that Section 4-10 related to ERISA plans. *See* Pet. App. 15a ("agree[ing] with the parties" that Section 4-10 related to ERISA plans); *id.* 25a ("The state law is conceded to relate to ERISA plans").[12]

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[12] Amici AARP, Br. 7-16, and the States, Br. 6-17, similarly argue that the law does not "relate to" ERISA plans, but amici cannot raise arguments the parties have not or cannot raise themselves. *See Reno* v. *Koray*, 515 U.S. 50, 55 n.2 (1995). The same rule precludes the radical argument of amicus United Policyholders that ERISA was not meant to apply to health benefit plans in the first place. Br. 14-21. In any case, ERISA governs "*any* plan, fund, or program" maintained "for the purpose of providing for its

In any event, Moran's new argument is meritless. Moran argues that Section 4-10 "neither refers to nor has a significant connection with ERISA plans" because it applies only to HMOs. Br. 20.[13] But as the Court of Appeals held, the Illinois law requires HMOs, "including those that are service providers for ERISA plans, to provide an independent review mechanism" for medical necessity determinations. Pet. App. 16a. The law plainly "has an effect on how benefit determinations are made, and, thus, squarely falls within ERISA's preemption clause." *Id.*

The amici States argue, for their part, that Section 4-10 does not "relate to" ERISA plans because it regulates only "medical treatment" decisions, and *Pegram* suggests that such laws are not pre-empted. Br. 13; *see id.* 17. *Pegram* has nothing to do with preemption, and we agree with the Solicitor General that it does not control the question here. U.S. Br. 7-11. Nor is the States' initial assumption—that independent review laws regulate "medical treatment" decisions—correct. The determinations at issue here are not treatment decisions, but coverage decisions, in which HMOs, pursuant to the terms of their plans, determine whether a service is a covered benefit. That determination requires plan

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participants or their beneficiaries, through the purchase of insurance or otherwise, (A) *medical, surgical, or hospital care or benefits* * * *." 29 U.S.C. § 1002(1) (emphases added).

[13] Moran suggests that Rush improperly refers to the Rush Certificate of Coverage as the "ERISA plan," and that Rush provided "no evidence that it, its HMO insurance contract or services, or its member Certificate, is an ERISA benefit plan." Moran Br. 16-17. Moran's second amended complaint, however, itself states that "Rush Prudential's Certificate of Coverage * * * is an ERISA governed employer sponsored welfare benefit plan." J.A. 32, 38. *See also Pegram* v. *Herdrich*, 530 U.S. 211, 223 (2000) (the "agreement between an HMO and an employer who pays the premiums may * * * provide elements of a plan by setting out rules under which beneficiaries will be entitled to care").

fiduciaries to interpret the terms of the plan; "medical necessity" is not some brooding omnipresence in the sky. It is defined by the terms of the plan, and its application requires interpretation of the terms of the plan. That makes it a coverage determination.

Contrary to the concern expressed by the AMA, preempting state independent review laws would hardly lead to "no regulation" of HMOs and their medical-necessity determinations. Br. 23. States remain free to provide that HMOs must afford specified levels of coverage and to define benefits that must be covered. The remedy for an HMO's failure to fulfill its coverage obligations is then an action under Section 502. What States cannot do under ERISA, however, is supply alternative state-law remedies to enforce the terms of an ERISA plan. Section 4-10 seeks to do just that, and is therefore preempted.

CONCLUSION

For the foregoing reasons, and those in petitioner's opening brief, the judgment below should be reversed.

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No. 00-1021

In the Supreme Court of the United States

RUSH PRUDENTIAL HMO, INC., PETITIONER

v.

DEBRA C. MORAN, ET AL.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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38 AP

QUESTION PRESENTED

Section 4-10 of the Illinois Health Maintenance Organization Act (215 Ill. Comp. Stat. Ann. 125/4-10 (West 1993 & Supp. 2001) requires a health maintenance organization to "provide a mechanism for * * * review by a physician * * * in the event of a dispute between the primary care physician and the Health Maintenance Organization regarding the medical necessity of a covered service proposed by a primary care physician," and provides that "[i]n the event that the reviewing physician determines the covered service to be medically necessary, the Health Maintenance Organization shall provide the covered service." The question presented is whether Section 4-10 of the Illinois Health Maintenance Organization Act is preempted by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.*

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BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

INTEREST OF THE UNITED STATES

This case concerns the interrelationship of the preemption provision of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1144(a), its insurance saving clause, 29 U.S.C. 1144(b)(2)(A), and ERISA's civil enforcement provision, 29 U.S.C. 1132(a) (1994 & Supp. V 1999). The Secretary of Labor has primary authority for enforcing and administering Title I of ERISA, see 29 U.S.C. 1002(13), 1136(b), which contains the ERISA provisions that are at issue. The United States filed an amicus brief in this case in the court below and at the petition stage in response to this Court's order inviting the Solicitor General to express the views of the United States.

STATEMENT

1. Respondent Debra C. Moran is a beneficiary under a medical benefit plan sponsored by her husband's employer and governed by ERISA. Pet. App. 3a. Respondent Rush Prudential HMO (Rush) provides "medically necessary" services under the plan. *Ibid.* Moran sought treatment in 1996 from her Rush-affiliated primary care physician for pain, numbness, loss of function, and decreased mobility in her

right shoulder. *Ibid.* Moran then consulted at her own expense with Dr. Julia Terzis, an out-of-network surgeon. *Id.* at 4a. Dr. Terzis recommended that Moran undergo a surgical microneurological procedure to correct her problem. *Ibid.* Two Rush-affiliated thoracic surgeons recommended a less expensive surgical procedure. *Id.* at 4a, 5a. Rush denied Moran's request for the procedure recommended by Dr. Terzis. *Id.* at 5a.

2. In January 1998, Moran sought independent review under Section 4-10 of the Illinois Health Maintenance Organization Act, 215 Ill. Comp. Stat. Ann. 125/4-10 (West 1993 & Supp. 2001) (reproduced at App., *infra*, 1a). Section 4-10 requires a Health Maintenance Organization (HMO), at the option of the patient, to submit to binding review by an unaffiliated physician whenever there is a disagreement between the patient's primary care physician and the HMO over whether a course of treatment is medically necessary. Pet. App. 6a.[1] When Rush did not act on her request, Moran filed an action in state court to require Rush to submit to independent review. *Id.* at 6a-7a. Rush removed the action to federal district court on the ground that the claim was completely preempted by ERISA, see *Metropolitan Life Ins. Co.* v. *Taylor*, 481 U.S. 58 (1987), but the district court remanded the case to the state court. Pet. App. 6a-7a, 28a-34a. In the meantime, Moran underwent the surgery by Dr. Terzis. *Id.* at 6a. She submitted the bill for $94,841.27 to Rush. *Ibid.*

3. On remand, the state court ordered Rush to submit to independent review. Pet. App. 7a, 36a. The independent reviewer determined that the surgery had been medically necessary. Rush, however, denied Moran's claim for reimbursement. *Id.* at 7a-8a, 56a-57a.

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[1] In 1999, after the events in this case, Illinois enacted a new statute that subjects the independent review process to more detailed requirements. 215 Ill. Comp. Stat. Ann. 134/1 *et seq.* (West 2000 & Supp. 2001).

4. Moran then sought an order from the state court requiring Rush to reimburse her for the surgery. Pet. App. 8a, 36a. Rush again removed the case to federal district court. That court refused to remand to state court, holding that Moran's suit to compel reimbursement for surgery was properly characterized as a claim for benefits under Section 502(a)(1)(B) of ERISA, 29 U.S.C. 1132(a)(1)(B). Pet. App. 41a-42a. On the merits, the court concluded that Section 4-10 is preempted by ERISA and is not saved as an insurance regulation under 29 U.S.C. 1144(b)(2)(A) because it does not spread risk. Pet. App. 42a-43a. Subsequently, the district court granted summary judgment to Rush. *Id.* at 58a. The court noted that the plan granted Rush "the broadest possible discretion" in making benefit determinations and held that Rush had not abused that discretion. *Id.* at 56a-58a.

5. The Seventh Circuit reversed. Pet. App. 1a-24a. The court concluded that Section 4-10 of the Illinois HMO Act "relates to" ERISA plans, Pet. App. 16a, but that it "regulates insurance" and therefore falls within ERISA's insurance saving clause, 29 U.S.C. 1144(b)(2)(A). Pet. App. 16a-18a. The court found that Section 4-10 satisfies the "common sense" test of insurance regulation because it "is directed at the HMO industry as insurers." *Id.* at 17a. The court also concluded that the terms of the statutory independent-review provision "are substantive terms of all insurance policies in Illinois by operation of law," *ibid.*, and are therefore "'integral' to the insurer/insured relationship," *id.* at 18a (quoting *UNUM Life Ins. Co.* v. *Ward*, 526 U.S. 358, 374-375 (1999)). In light of those determinations, the court did not find it necessary to reach the question whether Section 4-10 spreads risk. Pet. App. 18a n.3.

The court further held that Section 4-10 does not "creat[e] an alternative remedy scheme that conflicts with" Section 502(a) of ERISA, 29 U.S.C. 1132(a) (1994 & Supp. V 1999). Pet. App. 21a. It reasoned that, because Section 4-10 simply "adds to the contract * * * an additional dispute resolving

mechanism," *id.* at 22a, a suit "to enforce [Section 4-10] is simply a suit * * * 'to enforce rights' and 'to recover benefits' under the plan" under Section 502(a)(1)(B). *Id.* at 21a. The court concluded that unlike the state-law cause of action held preempted in *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41 (1987), Section 4-10 mandates insurance contract terms of the kind that were held in *UNUM* to be saved as the regulation of insurance. Pet. App. 23a.

Judge Posner, joined by three other judges, dissented from the denial of rehearing en banc. Pet. App. 24a-27a. In Judge Posner's view, the Illinois external review provision "establishes a system of appellate review of benefits decisions that is distinct from the provision in ERISA for suits in federal court to enforce entitlements conferred by ERISA plans." *Id.* at 25a. He expressed the view that that scheme improperly transforms contractual suits envisioned under Section 502(a)(1) into suits "for judicial review of the independent physician's decision." *Id.* at 26a.

SUMMARY OF ARGUMENT

Section 4-10 of the Illinois HMO Act "relates to" ERISA plans within the meaning of ERISA's preemption clause, 29 U.S.C. 1144(a), because the processing of benefit claims is a core concern of ERISA and Section 4-10 affects how HMOs make benefit determinations on behalf of ERISA plans.

Section 4-10, however, is saved from "relates to" preemption because it is a law that "regulates insurance" under ERISA's insurance saving clause, 29 U.S.C. 1144(b)(2)(A). The law regulates insurance as a matter of "common sense" because it is directed at HMOs, which are generally risk-bearing organizations that combine a traditional insurance function with the provision of medical services. The fact that some HMOs by contract transfer the risk to another entity —whether individual medical providers, a physicians' practice group, or a reinsurance company—does not alter the analysis, because the HMO generally remains ultimately liable for the medical care it has promised to provide. In any event, HMOs that retain a claims-processing function when they pass on risk to providers necessarily retain an insurance function, because claims processing is inextricably intertwined with the bearing of risk. For similar reasons, Section 4-10 also satisfies the factors used to determine what constitutes the "business of insurance" under the McCarran-Ferguson Act.

Even if a law comes within the terms of the insurance saving clause, it may nonetheless be preempted if it conflicts with a specific provision of ERISA. See *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 51-56 (1987). Section 4-10's provision for a private dispute resolution mechanism, however, does not conflict with Section 502(a) of ERISA. In contrast to *Pilot Life*, in which the Court addressed a state law creating a cause of action with alternative remedies to those in Section 502(a), Section 4-10 merely requires HMO contracts to include an arbitration-like dispute-resolution mechanism of the sort that private parties routinely include in contracts. Even under Section 4-10—as under labor arbitration provisions generally—a suit pursuant to Section 502(a) remains necessary to enforce a reviewer's decision. Moreover, unlike in *Pilot Life*, neither the external reviewer nor the court can award relief that goes beyond what is provided for in the plan itself. Section 4-10 does not interfere with any right guaranteed under Section 502(a), because the plan participant or beneficiary retains the ability to seek benefits directly in court in an action under Section 502(a).

ARGUMENT

I. SECTION 4-10 OF THE ILLINOIS HMO ACT "RELATES TO" ERISA PLANS FOR PURPOSES OF ERISA'S EXPRESS PREEMPTION PROVISION

A. Section 4-10 "Relates To" ERISA Plans Because It Governs How Plans Make Benefits Determinations

Under Section 514(a) of ERISA, 29 U.S.C. 1144(a), the provisions of ERISA "shall supersede any and all State laws insofar as they * * * relate to any employee benefit plan." Section 514(a) "indicates Congress's intent to establish the regulation of * * * [ERISA] plans 'as exclusively a federal concern.'" *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645, 651, 656 (1995) (quoting *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981)). Section 514(a) was designed "to ensure that plans and plan sponsors would be subject to a uniform body of benefits law," and thus "minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government." *Id.* at 656 (quoting *Ingersoll-Rand* v. *McClendon*, 498 U.S. 133, 142 (1990)); see *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 98-100 & n.20 (1983) (quoting remarks of Congressional sponsors). Accordingly, Section 514(a) is "clearly expansive" in its preemptive sweep. *Egelhoff* v. *Egelhoff*, 121 S. Ct. 1322 (2001).

In general, a state law "relate[s] to" an ERISA plan "if it has a connection with or reference to such a plan." *Egelhoff*, 121 S. Ct. 1322, 1327 (quoting *Shaw*, 463 U.S. at 97). Although "relates to" preemption is not without limits, *Travelers*, 514 U.S. at 655, where a state law purports to regulate matters at the core of ERISA—such as the content or administration of ERISA plans or the mechanisms for enforcing rights under the plans—the requisite connection to ERISA plans is present. See 514 U.S. at 657-658 (discussing

Shaw, *Alessi*, *Ingersoll-Rand*, and *FMC Corp.* v. *Holliday*, 498 U.S. 52, 60 (1990)).

Section 4-10 does not specifically refer to ERISA plans, but it does have the requisite connection to such plans. As the court of appeals held, by requiring an HMO to provide a mechanism for independent review of a benefit determination and to abide by the reviewer's decision, Section 4-10 "has an effect on how benefit determinations are made." Pet. App. 16a. Accord *Corporate Health Ins., Inc.* v. *Texas Dep't of Ins.*, 215 F.3d 526, 537 (5th Cir.), opinion on denial of reh'g, 220 F.3d 641 (5th Cir. 2000), petition for cert. pending, No. 00-665. Thus, Section 4-10 "squarely fall[s] within ERISA's preemption clause." Pet. App. 16a; see *Egelhoff*, 121 S. Ct. at 1325 (by binding "plan administrators to a particular choice of rules for determining beneficiary status," the state probate statute "implicates an area of core ERISA concern"); *Travelers*, 514 U.S. at 658 (ERISA preempts state laws that "mandate[] employee benefit structures or their administration").

B. *Pegram* v. *Herdrich* Is Not To The Contrary

1. This Court's recent decision in *Pegram* v. *Herdrich*, 530 U.S. 211 (2000), does not alter the conclusion that Section 4-10 "relates to" ERISA plans. In *Pegram*, an ERISA plan participant contended that an HMO had violated its fiduciary duties under ERISA by structuring its operations so that its physician-owners received greater profits if they held down the HMO's medical treatment expenses. The plaintiff alleged that the plan's physicians acted in a fiduciary capacity when they made "mixed eligibility and treatment decisions," *id.* at 229—decisions that mix questions concerning "the plan's coverage of a particular condition or medical procedure for its treatment" with "choices about how to go about diagnosing and treating a patient's condition," *id.* at 228. This Court held that "mixed eligibility [and treatment] deci-

sions by HMO physicians are not fiduciary decisions" subject to suit for breach of fiduciary duty under ERISA. *Id.* at 237.

Some statements in *Pegram*, if read in isolation, might suggest that such "mixed decisions"—which appear to be the subject of the disputes addressed by Section 4-10—are never fiduciary acts under ERISA, regardless of whether they are made by the treating physician or by another physician who is ruling on a beneficiary's internal appeal of the denial of her claim. See, *e.g.*, 530 U.S. at 231. If so, there might then be a question whether a state law governing mixed decisions "relates to" ERISA plans at all.[2]

The better reading of *Pegram*, however, is that it addresses only mixed decisions made by *treating* physicians. *Pegram* grew out of such a decision by the plaintiff's treating physician, see 530 U.S. at 215, 217, 231, and there is no indication that the plaintiff then sought review pursuant to the HMO's appeals process. Furthermore, although the Court did not regard the plaintiff's claim of a fiduciary breach as limited to that one incident, see *id.* at 226, the Court did appear to view her claim as involving only an attack on the compensation policies as they affected treating physicians. See, *e.g.*, *id.* at 228 (noting that treatment and eligibility decisions are "practically inextricable from one another * * * not merely because" they are "made by the same person, the *treating physician*," but also "because a great many * * * coverage questions are not simple yes-or-no questions") (emphasis added); *id.* at 232 ("physicians through whom HMOs act make just the sorts of decisions made by licensed medical practitioners millions of times every day").[3]

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[2] Such an argument was presented to the Fifth Circuit on rehearing in *Corporate Health* and rejected by that court. 220 F.3d. at 643-644. It was not briefed or addressed in the Seventh Circuit.

[3] The Secretary of Labor addressed the import of *Pegram* in an amicus brief filed with the Supreme Court of Pennsylvania in *Pappas* v. *Asbell*, 768 A.2d 1089 (2001), petition for cert. pending, No. 01-200, on remand from this Court, see *United States Healthcare Sys. of Pa., Inc.* v. *Pennsylvania Hosp. Ins. Co.*, 530 U.S. 1241 (2000). In *Pappas*, an HMO employee—who was not a treating physician—refused to authorize out-of-network treatment for an HMO subscriber. The Secretary contended that "the logic of *Pegram* applie[d]" to that case. Sec'y of Labor Br. at 11 n.6. However, the Secretary also noted that "[d]ifferent considerations may apply when an HMO * * * uses medical judgment in deciding whether a claim for treatment that has already been provided should be paid." *Id.* at 12 n.7. In any event, for the reasons given in the text, regardless of whether the claim is made before or after treatment, the better view is that an HMO employee deciding a claim is an ERISA fiduciary.

2. *Pegram* also must be read against the background of provisions of ERISA itself and longstanding Labor Department regulations that provide that plan administrators who make coverage decisions on review of the denials of claims for benefits *are* plan fiduciaries. Section 503(2) of ERISA, 29 U.S.C. 1133(2), provides that "[i]n accordance with regulations of the Secretary, every employee benefit plan shall * * * afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review *by the appropriate named fiduciary* of the decision denying the claim." See also 29 U.S.C. 1102(a) (plan must provide for "one or more named fiduciaries * * * to control and manage the operation and administration of the plan"; "'named fiduciary' means a fiduciary who is named in the plan instrument, or who, pursuant to a procedure specified in the plan, is identified as a fiduciary"). Thus, Section 503 of ERISA itself requires that appeals within a plan—even as to medical necessity issues that are decided by a non-treating physician—must be decided by someone who is subject to fiduciary responsibilities.[4]

Section 503(2) also requires ERISA plans to decide claims "[i]n accordance with regulations of the Secretary." 29 U.S.C. 1133. In regulations promulgated last year, the

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[4] Those responsibilities include that the decisionmaker "discharge his duties * * * in accordance with the documents and instruments of the plan." 29 U.S.C. 1104(a)(1)(D). Thus, the decisionmaker's fiduciary duty is to be faithful to the terms of the plan, not to favor the position of the claimant who took the appeal.

Secretary made clear that claimants must have an opportunity to appeal "an adverse benefit determination *to an appropriate named fiduciary*." 65 Fed. Reg. 70,268 (2000) (to be codified at 29 C.F.R. 2560.503-1(h)(1)) (emphasis added); *id.* at 70,269 (to be codified at 29 C.F.R. 2560.503-1(h)(3)(ii) and (*i*)(1)(ii)). The predecessor regulation, 29 C.F.R. 2560.503-1(g)(1)(2000), promulgated in 1977 (see 42 Fed. Reg. 27,426), likewise provided for review by "an appropriate named fiduciary or to a person designated by such fiduciary." See also Dep't of Labor Advisory Op. 81-50A, 1981 WL 17772, at *2 (June 4, 1981) (citing prior opinions).

More generally, "a person is a fiduciary with respect to a plan to the extent * * * he has any discretionary authority or discretionary responsibility in the administration of such plan." 29 U.S.C. 1002(21)(A)(iii). Mixed decisions involving medical necessity necessarily require the exercise of judgment, and for that reason they are "discretionary" rather than merely "ministerial." Personnel who make such judgments on appeal under an HMO's claims procedures are therefore fiduciaries under ERISA. See *Varity Corp.* v. *Howe*, 516 U.S. 489, 511-512 (1996); *id.* at 530 (Thomas, J., dissenting); *Pilot Life*, 481 U.S. at 53; Dep't of Labor Advisory Op. 92-24A, 1992 WL 337539, at *4 n.4 (Nov. 6, 1992). Accordingly, a state law that regulates such ERISA fiduciary decisions necessarily "relates to" ERISA plans under Section 514(a), even if the subject of the decision is "medical necessity" and the decisionmaker is a physician.

3. Even if *Pegram* were read to state that a medical necessity determination by a plan administrator is not the subject of an ERISA-based fiduciary obligation, *Pegram* still would not lead to the conclusion that Section 4-10 does not relate to ERISA plans. Although Section 4-10 does not directly regulate medical necessity determinations by, for example, specifying what treatments are medically necessary in certain defined circumstances (see Pet. App. 22a n.6),

it does regulate the processes to be used by HMOs (and thus by plans) to adjudicate disputes when medical necessity decisions are at issue. Nothing in *Pegram* suggests that—in the absence of ERISA's insurance saving clause, discussed below—States would have authority to regulate the claims-resolution processes utilized by ERISA plans.

II. SECTION 4-10 "REGULATES INSURANCE" FOR PURPOSES OF ERISA'S INSURANCE SAVING CLAUSE

ERISA's insurance saving clause provides that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance." That clause is one of a series of provisions of Section 514 that preserve certain other laws—state and federal—even though they "relate to" ERISA plans. By saving state laws that "regulate[] insurance," Section 514(b)(2)(A) "leaves room for complementary or dual federal and state regulation," *John Hancock Mut. Life Ins. Co.* v. *Harris Trust & Sav. Bank*, 510 U.S. 86, 98 (1993), and preserves the States' traditional role in insurance regulation.[5]

To determine whether a state law "regulates insurance" for purposes of the insurance saving clause, a court must first undertake a "common-sense" examination of whether the state law regulates insurance. *UNUM*, 526 U.S. at 367 (citing *Metropolitan Life*, 471 U.S. at 740, and *Pilot Life*, 481 U.S. at 48). To satisfy the "common-sense" test, "a law must

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[5] The insurance saving clause is qualified by the "deemer" clause, 29 U.S.C. 1144(b)(2)(B), which provides that an employee benefit plan shall not be "deemed to be an insurance company or other insurer * * * or to be engaged in the business of insurance * * * for purposes of any law of any State purporting to regulate insurance companies, [or] insurance contracts." The effect is to preclude States from "deem[ing]" self-insured plans to be insurers and thereby subjecting them to state insurance laws. *FMC Corp.* v. *Holliday*, 498 U.S. 57, 61, 62 (1990). We agree with the court of appeals (Pet. App. 18a) that, because the health plan here is insured, the "deemer clause" is inapplicable to this case. See *UNUM*, 526 U.S. at 367 n.2.

not just have an impact on the insurance industry, but must be specifically directed toward that industry." *Pilot Life*, 481 U.S. at 50. The Court then considers the three factors used to determine what constitutes the "business of insurance" under the McCarran-Ferguson Act. *UNUM*, 526 U.S. at 367. Those three factors—(1) whether the law transfers or spreads the policyholder's risk, (2) whether the law is an integral part of the policy relationship between the insurer and the insured, and (3) whether the law is limited to entities within the insurance industry—are helpful "guideposts" to be considered, rather than essential elements, each of which must be satisfied. *Id.* at 374-375.

The court of appeals in this case and the Fifth Circuit in *Corporate Health* agreed that the respective state independent review provisions come within the insurance saving clause. Both courts held that the provisions satisfy the "common sense" test and two of the three McCarran-Ferguson factors. See Pet. App. 18a; *Corporate Health*, 215 F. 3d at 538. Those conclusions are correct.

A. As A Matter Of "Common-Sense," Section 4-10 Regulates Insurance

1. Section 4-10 meets the common sense test of insurance regulation. In general, HMOs combine in various ways an insurance function (taking on the risk of beneficiaries' medical expenses in return for fixed payments) and a medical care function. As the court of appeals explained, that appears to be true under Illinois law, which recognizes HMOs as insurance vehicles. Pet App. 17a (citing *Anderson* v. *Humana, Inc.*, 24 F.3d 889, 892 (7th Cir. 1994)). That view also is supported by this Court's understanding of HMOs as "risk-bearing organizations," akin to traditional insurance companies. *Pegram*, 530 U.S. at 219. Indeed, this Court noted in *Pegram* that the Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, 87 Stat. 914, 42 U.S.C. 300e *et seq.*, "allowed the formation of HMOs that assume financial risks for the provision of health care services." 530 U.S.

at 233; see 42 U.S.C. 300e(c)(2) (qualified HMO must assume "full financial risk").[6] Because it appears that Section 4-10 is aimed exclusively at HMOs in their role of furnishing insurance, it regulates insurance from a "common-sense" perspective.

2. Petitioner argues that Section 4-10 does not regulate insurance because it is directed both to HMOs that concededly bear risk as insurers and to HMOs that petitioner asserts "act in a purely administrative role and devolve all risk onto their providers or onto a third-party insurer."

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[6] Petitioner's amici, American Association of Health Plans, *et al.*, assert (Br., 24 n.11) that Congress's enactment in 1973 of federal requirements for the administration of qualified HMOs is inconsistent with the proposition that Congress intended when it enacted ERISA in 1974 to allow the States to regulate HMOs that serve ERISA plan beneficiaries. Congress's concern in 1973 was that some restrictive state laws had prevented the development of HMOs. Congress therefore included in the 1973 Act a provision that exempts HMOs from state-law insurance requirements "respecting initial capitalization and establishment of financial reserves against insolvency," where such requirements would prevent HMOs from operating in accordance with the federal Act. See §§ 2, 87 Stat. 931 (§ 1311(a)(1)(D), 42 U.S.C. 30e-10(a)(1)(D)); S. Rep. No. 129, 93d Cong., 1st Sess. 26-27 (1973). The obvious premise of that partial preemption of state insurance laws was that many States *did* regard HMOs as insurers. Significantly, moreover, Congress preempted only certain provisions of state insurance law. This feature of the 1973 HMO Act underscores that when Congress enacted ERISA one year later, it anticipated that there were aspects of state insurance regulation that affected HMOs and would fall within the States's reserved power to "regulate[] insurance."

Petitioner's amici likewise err in relying (Br. 24) on the discussion in *Group Life & Health Ins. Co.* v. *Royal Drug Co.*, 440 U.S. 205, 226 (1979), of the treatment of prepaid health plans by the States at the time the McCarran-Ferguson Act was passed. State practices in 1945 do not control the interpretation of ERISA's insurance saving clause, which was enacted almost 30 years later, especially in light of the fact that the ERISA saving clause is broader than the McCarran-Ferguson Act's narrow exemption from the antitrust laws, at issue in *Royal Drug*. See note 8, *infra*. Moreover, the Court stated in *Royal Drug* that the contract between a prepaid plan and its members may be the "business of insurance" under the McCarran-Ferguson Act, even though the provider agreements challenged in that case were not. See *id.* at 227 n.34, 230 nn. 37-38.

Br. 38 (internal quotation marks and citation omitted). This effort to remove Section 4-10 from the scope of the insurance saving clause is unavailing.[7]

HMOs may split up their functions in various ways. For example, as petitioner notes (Br. 37-38), an HMO may contract to transfer its medical care function to providers who are not themselves employees of the HMO. Although the HMO assumes by contract the financial risk of members' medical expenses, it may also re-transfer (in petitioner's term "devolve," Br. 38) that risk to the medical providers by

[7] The Illinois HMO Act defines an HMO as an "organization formed * * * to provide or arrange for one or more health care plans under a system which causes any part of the *risk of health care delivery to be borne by the organization or its providers.*" 215 Ill. Comp. Stat. Ann. 125/1-2 (West 1993 & Supp. 2001) (emphasis added). The Act defines "[h]ealth care plan" to mean "any arrangement whereby any organization undertakes to *provide or arrange for and pay for or reimburse the cost of basic health care services* from providers selected by [a] Health Maintenance Organization and such arrangement consists of arranging for or the provision of such health care services, as distinguished from mere indemnification against the cost of such services." *Ibid.* (emphasis added). Those definitions make clear that the law applies only to HMOs that either bear the "risk of health care delivery" themselves or have undertaken that risk and then transferred it through contractual arrangements with their providers.

For this reason, petitioner's amici err in arguing (Br. 21) that Section 4-10 "applies to HMOs that perform purely *administrative* services for self-funded [*i.e.*, self-insured] plans" and that this supposed feature "destroys any attempt by the State to rely on" ERISA's insurance saving clause. Even if Section 4-10 were construed to apply to such HMOs, however, that would have no effect on the application of Section 4-10 to HMOs that insure *non*-self-insured ERISA plans. A state insurance law that includes self-insured plans among the insurers within its reach is still a law that regulates "insurance" within the meaning of the insurance saving clause, even though the deemer clause, 29 U.S.C. 1144(a)(2)(B), would preempt the *application* of that state insurance law to the self-insured plans. See *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724, 735-736 n.14, 740-747 (1985); *FMC*, 498 U.S. at 61 ("We read the deemer clause to exempt self-funded ERISA plans from state laws that 'regulat[e] insurance' within the meaning of the saving clause."); *cf. General Elec. Co.* v. *Gilbert*, 429 U.S. 125, 138 n.16 (1976). ("That General Electric self-insures does not change the fact that it is, in effect, acting as an insurer.").

paying them a fixed, per-patient ("capitation") fee. In doing so, the HMO may retain administrative functions (such as rendering decisions on claims) associated with the risk-bearing function. Regardless of how the HMO divides up the risk-bearing function and its associated administrative responsibilities (such as claims processing), however, Section 4-10 is still directed toward insurance, for two reasons.

First, the HMO's transfer of its risk by contract to another entity or entities (such as individual medical providers, a physicians' practice group, or a reinsurance company) does not alter its own continuing responsibility to its members for the costs of their medical care. As the law-review articles cited by petitioner (Br. 37, 38 n.13) recognize, even an HMO that has a "capitation" arrangement with medical providers nonetheless typically retains some risk, including the risk that the providers will become financially unable to provide services, since "[t]he HMO is legally committed to furnish care to its enrollees." J. P. Weiner & G. de Lissovoy, *Razing a Tower of Babel: A Taxonomy for Managed Care and Health Insurance Plans*, 18 J. Health Pol., Pol'y, & L. 75, 96 (1993); see also E.H. Morreim, *Confusion in the Courts: Managed Care Financial Structures and their Impact on Medical Care*, 35 Tort & Ins. L.J. 699, 705-706 (2000) ("if the physicians use up all of their [capitation] funds too quickly, the [HMO] is still obligated to provide care and could potentially be required to infuse money beyond the contracted capitation amount").

Second, even HMOs that pass on risk to network providers necessarily retain an insurance function, because they retain a claims-processing function and claims processing is inextricably intertwined with insurance and the bearing of risk. Claims processing is the means by which an insurer pays for a risk it has undertaken, and the regulation of claims processing therefore is a central feature of state insurance law. See, *e.g.*, *Metropolitan Life*, 471 U.S. at 728 n.2 ("Laws regulating aspects of transacting the business of

group insurance include, for example, those regulating *claims practices* or rates.") (emphasis added); *UNUM*, 526 U.S. at 375 n.5 (same). That is true regardless of whether the entity that does the claims processing also bears the risk or is an independent entity that has contracted with risk-bearing entities (such as insurance companies or providers operating under a capitation agreement) to perform this insurance function. Cf. *Barnett Bank* v. *Nelson*, 517 U.S. 25, 39 (1996) (regulation of agents of insurance companies relates to the "business of insurance"). An insurer that reinsures 100% of its risks, but continues to process claims, is still an insurer. Such an insurer may not simply contract itself out of state insurance law that is saved under ERISA by offloading the primary risk-bearing function to an independent entity.

B. Section 4-10 Satisfies At Least Two Of The McCarran-Ferguson Factors

1. The McCarran-Ferguson factors reinforce the common-sense conclusion that Section 4-10 is a law regulating insurance. Regardless of whether the risk-spreading factor is satisfied—an issue left open by the court of appeals, Pet. App. 18a n.3—that court correctly concluded that Section 4-10 satisfies the other two factors. *Id.* at 18a.[8]

[8] The Court in *UNUM* noted, but found it unnecessary to pursue, the argument of the United States that "[i]nsofar as the notice-prejudice rule shifts the risk of late notice and stale evidence from the insured to the insurance company in some instances, it has the effect of raising premiums and spreading risk among policyholders." 526 U.S. at 374. Similarly here, Section 4-10 can be viewed as spreading the risk of loss resulting from the erroneous denial of claims by an HMO.

Petitioner (Br. 40) and its amici (Br. 29) rely on the statement in *Pireno* that the transfer of risk occurs "at the time the [insurance] contract is entered." See 458 U.S. at 130-131. But as the Court later pointed out in *Department of Treasury* v. *Fabe*, 508 U.S. 491, 503-504 (1993), where it upheld a state statute giving priority to policyholders in the event of insolvency, that statement in *Pireno* "presumes that the insurance contract in fact will be enforced," for "[w]ithout performance of the terms of the insurance policy, there is no risk transfer at all." Like the priority statute

Because Section 4-10 creates a procedural right enforceable by the insured against the HMO as insurer, it is integral to the relationship between the insured and the insurer. See Pet. App. 17a-18a. Petitioner relies (Br. 41) on the Court's conclusion in *Pireno* that an insurer's use of a peer review committee was not an "integral part of the policy relationship between insurer and insured." See 458 U.S. at 131. In *Pireno*, however, the insurer's arrangement with the peer review committee was separate from its contract with its insured, *id.* at 131-132; the committee's opinions were not binding on the insurer; and the committee therefore was not part of "the claims adjustment process itself," but was instead merely "ancillary" to it, *id.* at 134 n.8. See *Fabe*, 508 U.S. at 503. Here, by contrast, Section 4-10 "dictates the terms of the relationship between the insurer and the insured," *UNUM*, 526 U.S. at 374, because the independent review process it mandates is triggered by the insured, the independent reviewer's decision is binding on the HMO, and the independent review therefore is an integral part of the claims-adjustment process. See also note 8, *supra*. Furthermore, because the Illinois law is aimed exclusively at HMOs in the furnishing of insurance (see pp. 12-16, *supra*), it also satisfies the third McCarran-Ferguson factor. Pet. App. 18a.

2. If Section 4-10 is not saved as a regulation of insurance, then it would appear that state laws mandating that

in *Fabe*, Section 4-10 is concerned with the performance of undertakings in the insurance contract. Moreover, *Pireno* (like *Royal Drug*, also cited by petitioner (Br. 40)), involved the *second* clause of Section 2(b) of the McCarran-Ferguson Act, 15 U.S.C. 1012(b), which was designed to carve out only a narrow exemption from the federal antitrust laws, while the *first* clause, at issue in *Fabe*, preserves to the States broad regulatory authority over the business of insurance generally. See 508 U.S. at 504-505. ERISA's insurance saving clause parallels the *first* clause of Section 2(b) of the McCarran-Ferguson Act in its broader purpose of preserving general authority over insurance to the States. See *Metropolitan Life*, 471 U.S. at 740-741, 744 n.21; U.S. Amicus Br. Pet. Stage (at 15-16), *Kentucky Ass'n of Health Plans, Inc.* v. *Miller*, No. 00-1471.

HMOs provide certain medical benefits would likewise not be saved. This Court made clear in *Metropolitan Life*, however, that state laws mandating that *non*-HMO health insurers provide certain benefits are saved by ERISA's insurance saving clause and may be applied to health insurance policies purchased by ERISA plans. Under petitioner's argument, therefore, while state laws requiring other health insurers to provide certain benefits are valid under ERISA, state laws requiring HMOs to provide the same benefits are preempted. Petitioner does not attempt to explain why Congress would have intended that ERISA plans obtain that extra exemption from state insurance law merely by purchasing HMO coverage rather than traditional health insurance.

III. SECTION 4-10 DOES NOT CONFLICT WITH SECTION 502(a) OF ERISA, WHICH PROVIDES THE EXCLUSIVE CIVIL ACTION UNDER ERISA

A. Under *Pilot Life*, A State Insurance Law That Conflicts With A Provision Of ERISA Is Preempted

Even if a state law "regulates insurance" and is therefore saved from "relates to" preemption, it may still be preempted if it "conflict[s] with a substantive provision of ERISA." *Pilot Life*, 481 U.S. at 57. More generally, "this Court has repeatedly declined to give broad effect to saving clauses where doing so would upset the careful regulatory scheme established by federal law." *Geier* v. *American Honda Motor Co.*, 529 U.S. 861, 870 (2000) (internal quotation marks omitted); see also *id.* at 869 (concluding that the saving clause at issue there "does *not* bar the ordinary working of conflict pre-emption principles"). Thus, although Section 4-10 is a law regulating insurance, there remains the inquiry whether it is nonetheless preempted because it conflicts with a provision of ERISA.[9]

[9] We note, in this regard, that both the House and Senate have passed legislation this year that would amend ERISA to require plans to adopt external review procedures for denials of claims for benefits. See, *e.g.*, H.R. 2563, 107th Cong., 1st Sess., § 104(a); S. 1052, 107th Cong., 1st Sess., § 104(a) (2001). Both bills would set out in federal law new detailed and comprehensive procedures for external review, including timelines for review, qualifications of external reviewers, and limitations on the availability of remedies. Should Congress adopt external review procedures under ERISA, those provisions might well preempt any state external review procedures.

In Section 502(a) of ERISA, 29 U.S.C. 1132(a), Congress included "a 'carefully integrated' civil enforcement scheme that 'is one of the most essential tools for accomplishing the stated purposes of ERISA.'" *Ingersoll-Rand*, 498 U.S. at 137 (quoting *Pilot Life*, 481 U.S. at 52, 54 (additional quotation and citation omitted)). That "comprehensive" scheme "represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans." *Pilot Life*, 481 U.S. at 54; see also *Mertens* v. *Hewitt Assocs.*, 508 U.S. 248, 252 (1993). Section 502(a)(1)(B)—the specific provision pertinent here—confers upon a participant or beneficiary a federal cause of action "to recover benefits due to him under the terms of the plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. 1132(a)(1)(B).

In *Pilot Life*, this Court concluded that "ERISA's civil enforcement [remedies were intended to] be exclusive." 481 U.S. at 57. In particular, *Pilot Life* held that a state common law tort and contract action asserting improper processing of a claim for benefits conflicted with Section 502(a)(1)(B)'s provision for a federal cause of action by a participant or beneficiary to recover on a claim for benefits due under the plan or to enforce his rights under the plan, and with Section 502(a)(2)'s provision for a suit by a participant or beneficiary for breach of fiduciary duty. 481 U.S. at 53-57.

In *Metropolitan Life*, by contrast, this Court held that a state mandated-benefit law is within the scope of the insur-

ance saving clause and therefore may be applied to insurance policies issued to ERISA plans. See 471 U.S. at 739-747. The Court reasoned that such a law "regulates the terms of certain insurance contracts," and thus is saved under a clause that preserves state laws "which regulate[] insurance." *Id.* at 740. That conclusion was reinforced by the deemer clause, which provides that an employee benefit plan shall not be deemed to be an insurance company "for purposes of any law of any State purporting to regulate insurance companies, *insurance contracts*, banks, trust companies, or investment companies." 29 U.S.C. 1144(b)(2)(B) (emphasis added). The Court reasoned that the deemer clause "makes explicit Congress's intention to include laws that regulate insurance contracts within the scope of the insurance laws preserved by the saving clause," for otherwise it would have been unnecessary for the deemer clause explicitly to exempt such laws from the saving clause when they are applied directly to benefit plans. 471 U.S. at 741; see also *FMC*, 498 U.S. at 62-63, 64.

The state mandated-benefit laws saved under *Metropolitan Life* do not conflict with Section 502(a) of ERISA because the mandated benefit is incorporated into the insurance policy purchased by the ERISA plan (and therefore into the plan itself). The mandated-benefit requirement can then be enforced in a suit by a participant or beneficiary under Section 502(a)(1)(B) "to recover benefits due under the terms of his plan" or "to enforce his rights under the terms of the plan." See *UNUM*, 526 U.S. at 377. The same analysis cannot be applied to a state law creating a cause of action for compensatory and punitive damages, as in *Pilot Life*, because private parties could not meaningfully contract for such a cause of action, and the state law creating such a cause of action therefore would not merely "regulate[] the substantive terms of the insurance contract." *Metropolitan Life*, 471 U.S. at 741. As we explain more fully below,

Section 4-10 does not conflict with Section 502(a) under these principles.

B. Section 4-10's Provision For Private Dispute Resolution Does Not Conflict With Section 502(a)

As petitioner repeatedly emphasizes, Section 4-10 "consists of a form of compulsory binding arbitration rather than a judicial cause of action." Br. 31 n.10; see also *id.* at 17, 22, 24, 27. Private parties routinely contract to arbitrate disputes. Section 4-10 merely makes an arbitration-like clause a mandatory provision of contracts between HMOs in Illinois and those who purchase their services, including ERISA plans. Both the duty to arbitrate under that provision and any award of benefits in favor of a participant or beneficiary may be enforced in a suit against the plan under Section 502(a)(1)(B) of ERISA. Furthermore, neither the external reviewer nor the court in a suit under Section 502(a)(1)(B) to enforce the reviewer's decision may award relief that goes beyond what is provided for in the plan itself—an award of benefits, in kind or in cash, for medically necessary services. Because the arbitration-like mechanism that Section 4-10 requires to be included in HMO insurance policies does not authorize a civil action in court or any relief beyond that provided in the plan itself, it does not conflict with Section 502(a).

1. a. The text of Section 502 gives no indication that it was intended to prevent the operation of private, non-judicial modes of dispute resolution, such as that provided for under Section 4-10. Section 502 is entitled "Civil enforcement." Submission of a dispute to an independent reviewer under Section 4-10 constitutes *compliance* with an ERISA plan; it is not "enforcement" of the plan in the sense that Section 502 uses that term, because a private arbitrator does not have the coercive powers of a court. The reviewer's decision can be enforced only in a subsequent judicial action, such as the present action under Section 502(a). *United*

Paperworkers Int'l Union v. *Misco, Inc.*, 484 U.S. 29, 37 (1987); see also *Iron Workers Local 272* v. *Bowen*, 624 F.2d 1255, 1259 (5th Cir. 1980) (court in Section 502(a) suit may order trustees to comply with arbitrator's award). Moreover, subsection (a) of Section 502, which is entitled "Persons entitled to bring a civil action," is itself concerned *solely* with creating causes of action in court; it provides that "[a] civil action may be brought" by certain parties in specified circumstances for specified relief. 29 U.S.C. 1132(a) (1994 & Supp. V 1999). Its text does not address private dispute-resolution mechanisms.

b. Section 4-10 does not interfere with any rights granted by Section 502(a). The relevant provision is Section 502(a)(1)(B), which grants a right to "a participant or beneficiary" to bring a cause of action "to recover benefits due to him under the terms of his plan [or] to enforce his rights under the terms of the plan." 29 U.S.C. 1132(a)(1)(B). Section 4-10 does not interfere with that right in any aspect. Nothing in Section 4-10 purports to force a plan participant or beneficiary to invoke the external review mechanism that Section 4-10 obligates the HMO to make available. Instead, a plan participant or beneficiary retains the right to bring an action directly in court under Section 502(a)(1)(B) to challenge the denial of a requested service. Indeed, the preamble to the claims-processing regulations recently promulgated by the Secretary of Labor notes that, "while [external review] procedures as established by State law are not preempted by the regulation, * * * claimants cannot be required to submit their claims to such procedures in order to be entitled to file suit under section 502(a) of the Act." 65 Fed. Reg. 70,254 (2000); accord *id.* at 70,254 n.33.[10] Further-

[10] See also 65 Fed. Reg. at 70,254, 70,270-70,271 (to be codified at 29 C.F.R. 2560.503-1(k)) (explaining that claims regulation does not preempt state law regulating insurance unless it prevents application of a requirement of the regulation, and that state external-review laws "are beyond the scope of the regulation").

more, if the participant or beneficiary chooses to invoke the procedure that Section 4-10 affords, he retains the right to bring an action under Section 502(a)(1)(B) of ERISA—either to recover the benefits due if the independent reviewer rules in his favor, or to challenge the decision if it is adverse. Thus, Section 4-10 does not purport to—and may not be applied to—interfere with a participant's or beneficiary's rights under Section 502(a)(1)(B).

Neither Section 4-10 nor the Secretary's claims-processing regulations confer a similar right on an HMO or an ERISA plan insured by an HMO to bypass the independent review procedure. But that omission does not conflict with Section 502(a)(1)(B). That Section does not even mention, much less confer a right of immediate access to court on, an HMO or ERISA plan. See *Harris Trust & Sav. Bank* v. *Salomon Smith Barney*, 530 U.S. 238, 246 (2000).

c. A private, non-judicial arbitration-like mechanism to settle disputes is fully consistent with the exclusivity of the federal cause of action under Section 502(a)(1)(B). In *Pilot Life*, this Court noted that "the pre-emptive force of § 502(a) was modeled on the exclusive remedy provided by § 301 of the Labor-Management Relations Act, 1947." See 481 U.S. at 52. Binding arbitration is fully consistent with Section 301's provision of an exclusive cause of action to enforce a collective bargaining agreement. Indeed, arbitration is strongly encouraged by federal labor law. See, *e.g.*, *Teamsters* v. *Lucas Flour Co.*, 369 U.S. 95 (1962); *Textile Workers* v. *Lincoln Mills*, 353 U.S. 448, 455-456 (1957). The same conclusion follows with respect to Section 502(a) of ERISA.[11]

[11] In *Pilot Life*, the Court explained that "[t]he expectations that a federal common law of rights and obligations under ERISA-regulated plans would develop, indeed, the entire comparison of ERISA's § 502(a) to § 301 of the LMRA, would make little sense if the remedies available to ERISA participants and beneficiaries under § 502(a) could be supplemented or supplanted by varying state laws." 481 U.S. at 56. As noted in text, Congress's plan, embodied in Section 301, for a "federal common law

The logic of petitioner's contrary argument is that Congress intended that Section 502(a)(1)(B) provide not only the exclusive judicial remedy, but also the exclusive binding mechanism of any sort for resolving disputes over medical necessity or other questions arising under an ERISA plan. If so, petitioner's position is necessarily in deep tension with permitting binding voluntary agreements to arbitrate benefit disputes. Yet, since 1978, Department of Labor regulations have recognized that arbitration of disputes regarding plan benefits is permissible under ERISA. See generally *Circuit City Stores, Inc.* v. *Adams*, 532 U.S. 105, 116 (2001) (discussing benefits of arbitration); *Chappel* v. *Laboratory Corp. of America*, 232 F.3d 713, 724 (9th Cir. 2000). Those regulations provide that when a collective bargaining agreement contains procedures (including arbitration) for the resolution of disputes, those procedures will generally be deemed to satisfy the requirements of ERISA that a plan's dispute-resolution procedures must be fair and reasonable. 29 C.F.R. 2560.503-1(b)(2)(i) (1978, 2000). That provision has been carried forward in the Secretary's new claims-processing regulations. See 65 Fed. Reg. at 70,266 (to be codified at 29 C.F.R. 2560-503-1(b)(6)); see also *id.* at 70,267 (to be codified at 29 C.F.R. 2560.503-1(c)(4)(ii)).[12]

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of rights and obligations under" labor contracts is entirely consistent with permitting binding private arbitration of disputes under those contracts. It follows that, contrary to petitioner's suggestion (Br. 25 n.6), Congress's intention that courts develop a federal common law of rights and obligations under ERISA plans is consistent with permitting arbitral mechanisms, like that provided by Section 4-10, for resolving disputes under ERISA plans. Moreover, as is true under Section 301 of the LMRA, the basic ERISA plan contract remains governed by federal law, although by virtue of the insurance saving clause, some provisions of that contract may be mandated by state law. Compare *Lincoln Mills*, 353 U.S. at 457 (discussing absorption of state law into federal law under Section 301).

[12] Petitioner argues (Br. 22 n.5) that Section 4-10 "conflicts with ERISA's fiduciary requirements" because Section 503 of ERISA requires plans to provide for review of denied claims by a fiduciary. See pp. 9-10, *supra*. Section 503, however, governs internal plan appeals, not external review; in this case, respondent has already invoked her right of internal appeal to a named fiduciary. Section 4-10 applies only "in the event of a dispute between the primary care physician and the [HMO] regarding the medical necessity of a covered service"—*i.e.*, only *after* the HMO, acting as plan administrator through a plan fiduciary, has made its final decision. See also 65 Fed. Reg. at 70,270-70,271 (claims-processing regulations do not preempt state law "merely because such State law establishes a review procedure * * * involving adverse benefit determinations under group health plans so long as the review procedure is conducted by a person other than * * * *plan fiduciaries*") (emphasis added) (to be codified at 29 C.F.R. 2560-503.1(k)(2)(i)).

Petitioner's amici suggest (Br. 27 n.13) that the Federal Arbitration Act (FAA), 9 U.S.C. 1 *et seq.*, would preserve a plan's or HMO's ability to provide for arbitration, if it voluntarily chooses to do so, even if the external review procedure under Section 4-10 is preempted because the arbitrator is not a plan fiduciary. But if Section 503 precludes binding arbitration by a non-fiduciary, then there is a substantial question whether the FAA could render such arbitration lawful under ERISA. The FAA could apply to ERISA plans only by virtue of a saving provision for other federal laws that is quite similar to the saving provision for state laws regulating insurance. See 29 U.S.C. 1144(d) ("Nothing in this subchapter shall be construed to * * * modify, invalidate, impair, or supersede any law of the United States."). Thus, if the insurance saving clause does not save a state insurance law providing for arbitration of insurance disputes, it is unclear how Section 1144(d) would save a federal statute authorizing arbitration of such disputes. But even if the FAA would apply by virtue of Section 1144(d) and protect voluntary agreements to arbitrate in the manner amici assert, the McCarran-Ferguson Act also is made applicable under ERISA by Section 1144(d), and that Act independently preserves a state insurance law (like Section 4-10) that requires arbitration clauses in insurance contracts. Cf. *Metropolitan Life*, 471 U.S. at 744-745 n.21. Application of the McCarran-Ferguson Act of course "lends further support to" the validity of Section 4-10. *Ibid.*

d. The fact that the arbitration-like procedure here is mandated by the State as a term of the underlying contract of insurance does not create a conflict with Section 502(a) of ERISA. Section 502(a), like Section 301 of the LMRDA, does not regulate the terms of the underlying contract. Each takes the contract as it finds it.

Many saved state insurance laws, such as the mandated-benefits law in *Metropolitan Life*, will in effect add terms to ERISA plans. So long as the state insurance law does not

attempt to add a contract term that conflicts with a provision of ERISA itself, the fact that the state law imposes the term on an unwilling insurer does not render it unenforceable in an action by a participant or beneficiary under Section 502(a)(1)(B). Moreover, the procedure that is incorporated into insurance contracts pursuant to Section 4-10 is well within the range of standard arbitration-like mechanisms that are accepted contractual arrangements for private resolution of disputes in a wide range of settings—including especially in the collective bargaining setting in which many ERISA plans are created.

e. Petitioner notes (Br. 21-22) that in the absence of Section 4-10, the court in a suit under Section 502(a)(1)(B) would review the *plan's* decision only for abuse of discretion, because the plan in this case vests discretion in its fiduciaries to construe and apply the plan. See *Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101, 114 (1989). By contrast, petitioner continues, the court in a Section 502(a)(1)(B) action brought after Section 4-10 has been invoked would review the *external reviewer's* decision under the deferential standard used for review of an arbitrator's decision. That fact does not create a conflict with Section 502(a)(1)(B).

Section 502(a)(1)(B), like Section 301 of the LMRA (29 U.S.C. 185), does not itself mandate any particular standard of review. Accordingly, in *Firestone*, the Court held that it was appropriate to look to background principles of trust law *and the terms of the plan* to determine the standard of review in a Section 502(a)(1)(B) action. Here, the terms of the plan, as required by state law, provide for arbitration-like external review that is binding on the plan. In a Section 301 action following arbitration of a dispute in which the contract provides that "the arbitrator's decision is final and binding upon the parties," *Misco*, 484 U.S. at 32, this Court has held that a deferential standard should be applied in reviewing the arbitrator's decision. *Id.* at 37-38. In a Section 502(a)(1)(B) action following review of an HMO's decision

under Section 4-10, the court can draw on those same background principles, consistently with Section 502(a), and apply a deferential standard to the independent reviewer's decision.[13] Thus, under Section 502(a)(1)(B), as under Section 301, the standard of review is dictated not by the statutory authorization to file a civil action, but by the nature of the suit and the terms of the underlying contract. Compare, *e.g.*, *Misco* (deferential review of arbitrator's decision) with *Bowen* v. *United States Postal Service*, 459 U.S. 212 (1983) (trial de novo in employee's suit where union declined to file grievance).

f. Finally, Section 4-10 is fully consistent with this Court's decision in *Pilot Life*. In that case, the Court reasoned that Section 502(a) provides the exclusive avenue for *judicial* relief for ERISA participants and beneficiaries whose claims for benefits are denied—not that Section 502(a) provides the sole permissible mechanism for resolving benefit disputes. After noting that causes of action outside Section 502(a) would lead to the award of judicial remedies, such as compensatory and punitive damages, that Congress had rejected, 481 U.S. at 53-54, the Court concluded that "[t]he policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA," *id.* at 54. That reasoning clearly prevents a State from adopting causes of action under state law to enforce the terms of an ERISA plan (including any incorporated provisions of state law) as an alternative to the cause of action under federal law in Section 502(a)(1)(B). For the same reasons, a State could not

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[13] Of course, Section 4-10 does not specify a standard of review. Accordingly, if application of the deferential standard employed in Section 301 cases somehow conflicts with Section 502(a), the answer would be to adopt a standard of review consistent with Section 502(a), not to declare Section 4-10 preempted.

under any circumstances make a plan or its insurer liable to the participant or beneficiary for punitive damages. Such a requirement would be far removed from what private parties might ordinarily contract for and would directly upset the policy choices reflected in Congress' inclusion of certain remedies and the exclusion of others.

The same concerns are not implicated by a state law giving plan participants a right to arbitrate their claims, as long as federal law and the terms of the plan (including any validly incorporated provisions of state law) govern in the arbitration and the arbitrator's award is enforceable only in an action under Section 502(a)(1)(B). Because Section 4-10 provides no relief beyond that provided for in the plan itself and the enforcement mechanism for obtaining benefits under the plan remains a Section 502(a)(1)(B) action, it does not pose the challenge to Congress's policy choices that the Court addressed in *Pilot Life*.

Furthermore, the Court reasoned in *Pilot Life* that Congress was "well aware" when it patterned Section 502(a)(1)(B) of ERISA after Section 301 of the LMRA that Section 301 displaced all state actions for violations of contracts between an employer and a labor organization. See 481 U.S. at 55. Congress presumably was equally well aware that Section 301 does *not* bar arbitration clauses in such contracts. Indeed, the two cases on which the Court relied in *Pilot Life* in describing how Section 301 of the LMRA should inform the interpretation of Section 502(a) of ERISA—*Lueck* and *Lucas Flour*—both involved disputes related to arbitration clauses.[14]

[14] In its amicus brief in *UNUM*, the United States suggested (at 19-25) that there may be reasons for the Court to reconsider the portion of *Pilot Life* discussing Section 502 to the extent it is read to mean that a cause of action provided by a state law regulating insurance would in all circumstances be preempted by Section 502. See *UNUM*, 526 U.S. at 377 n.7 (stating that the Court "need not address" that argument); see also *Franchise Tax Bd.* v. *Construction Laborers Vacation Trust*, 463 U.S. 1, 25 (1983). That portion of the United States' amicus brief in *UNUM*, however, reflected a particular concern with the possible availability of a cause of action for state-created remedies or sanctions to enforce substantive state insurance law where the causes of action provided under Section 502(a) itself were not suited to that purpose. See U.S. *UNUM* Br. 22-23 & n.12, 24 n.13, 25 & n.14; see *e.g.*, *Metropolitan Life*, 471 U.S. at 734 (suit by state attorney general to enforce mandated-benefits law); *Franchise Tax Bd.*, 463 U.S. at 24-26 (action by state tax agency to levy against plan trust). The *UNUM* brief also recognized (at 24 n.13) that "notwithstanding the savings clause, an insurance law that conflicts with a provision of ERISA itself is preempted by virtue of the Supremacy Clause."

This case involves not a state-created cause of action in court, as in *Pilot Life*, but a mandatory contractual provision for private dispute resolution that, like the state-law provision at issue in *UNUM*, can readily be enforced in a suit under Section 502(a)(1)(B) of ERISA itself. Therefore, as in *UNUM*, there is no occasion for the Court to address state causes of action in situations in which such a suit cannot be brought under Section 502(a).

2. Petitioner argues (Br. 19) that permitting the States to enforce insurance laws like Section 4-10 "would nullify Congress' intent to establish a uniform scheme for enforcing rights under ERISA plans." See also Br. 26-30. That effect is simply a product of ERISA's insurance saving clause, which contemplates some disuniformity as "the inevitable result of the congressional decision to 'save' local insurance regulation." *UNUM*, 526 U.S. at 376 n.6. It is therefore well-settled that specific terms of plans may be affected indirectly by state insurance regulations. See, *e.g.*, *Metropolitan Life*, 471 U.S. at 747. As noted, the relevant distinction is not between substantive terms (such as mandated benefits) and procedural terms, but between state laws that require contractual provisions (including procedural provisions) and state laws that create duplicative causes of action or distinct remedies, such as punitive damages.[15] In *UNUM*, for

[15] Petitioner argues (Br. 29), for example, that if Section 4-10 is not preempted, "administrators of nationwide ERISA plans could no longer develop a uniform medical necessity standard." Of course, state mandated-benefits laws, which petitioner concedes (Br. 30, 32) are valid, could define "medical necessity" in a variety of ways, and insured plans would have to follow those definitions, no matter how much variation was intro-

example, this Court held that a state law governing the effects of a late notice of claim by the insured—a paradigmatically procedural provision—is saved by the insurance saving clause and therefore not preempted. Indeed, mandated-benefits laws create very substantial disuniformity at the heart of the ERISA scheme by varying the benefits due under a plan in different States, and they impose a serious administrative burden by requiring insurers administering ERISA plans to consider state law before accepting or rejecting each claim. By contrast, external review provisions like Section 4-10 affect only the relatively small number of benefit disputes that cannot be resolved internally. Litigation of such disputes under Section 502(a)(1)(B) necessarily proceeds—even under petitioner's account—on a case-by-case basis in any event.

CONCLUSION

The judgment of the Seventh Circuit should be affirmed.
Respectfully submitted.

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duced. Indeed, such mandated-benefits laws would likely introduce more disuniformity than case-by-case determination by external reviewers of "medical necessity" in a variety of individual cases.

* The Solicitor General is recused in this case.

APPENDIX

215 Ill. Comp. Stat. Ann. 125/4-10 (West 1993 & Supp. 2001) provides in pertinent part:

> Each Health Maintenance Organization shall provide a mechanism for the timely review by a physician holding the same class of license as the primary care physician, who is unaffiliated with the Health Maintenance Organization, jointly selected by the patient (or the patient's next of kin or legal representative if the patient is unable to act for himself), primary care physician and the Health Maintenance Organization in the event of a dispute between the primary care physician and the Health Maintenance Organization regarding the medical necessity of a covered service proposed by a primary care physician. In the event the reviewing physician determines the covered service to be medically necessary, the Health Maintenance Organization shall provide the covered service.

September 10, 2001

(6)

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No. 00-1021

IN THE

Supreme Court of the United States

RUSH PRUDENTIAL HMO, INC.,

Petitioner,

v.

DEBRA C. MORAN AND STATE OF ILLINOIS,

Respondents.

On Writ Of Certiorari
To The United States Court Of Appeals
For The Seventh Circuit

BRIEF OF AMERICAN ASSOCIATION OF HEALTH PLANS, INC., AMERICAN BENEFITS COUNCIL, AND HEALTH INSURANCE ASSOCIATION OF AMERICA, INC., AS *AMICI CURIAE* IN SUPPORT OF PETITIONER

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QUESTION PRESENTED

Whether the external review provision of the Illinois Health Maintenance Organization Act, 215 ILL. COMP. STAT. 125/4-10, is preempted by the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq*.

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BRIEF OF AMERICAN ASSOCIATION OF HEALTH PLANS, INC., AMERICAN BENEFITS COUNCIL, AND HEALTH INSURANCE ASSOCIATION OF AMERICA, INC., AS *AMICI CURIAE* IN SUPPORT OF PETITIONER

INTEREST OF *AMICI CURIAE*[1]

The question presented in this case is whether Illinois' independent review statute—which requires health maintenance organizations to submit disputed "medical necessity" coverage determinations to the binding judgment of a non-plan physician—is preempted by ERISA. *Amici* have a vital interest in the correct resolution of this case, because each (through its members) has a significant stake in preserving uniformity in the federal law governing employee welfare benefits plans, and each (through its members) will be adversely affected by a decision upholding a State's authority to enact state-law remedies that constitute alternatives to ERISA's exclusive civil enforcement scheme.

The American Association of Health Plans, Inc. ("AAHP") is the national association for the managed health care community. Its membership includes health maintenance organizations, preferred provider organizations, third party health benefit administrators, health care utilization review organizations, prepaid limited health service plans, and other integrated health care delivery systems. AAHP represents more than 1000 managed health care organizations serving nearly 150 million Americans. AAHP's mission is to advance health care quality and affordability through leadership in the health care community, advocacy, and the provision of services to member health plans.

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[1] Pursuant to this Court's Rule 37.3(a), letters of consent from all parties to the filing of this brief have been filed with the Clerk. Pursuant to this Court's Rule 37.6, *amici* state that this brief was not authored in whole or in part by counsel for any party, and that no person or entity other than *amici*, its members, or its counsel made a monetary contribution to the preparation or submission of this brief.

The American Benefits Council ("Council") is one of the nation's leading advocates of employer-sponsored benefits programs. Its members sponsor, administer, or provide services to health, retirement, and stock compensation plans covering more than 100 million Americans. The Council is dedicated to promoting sensible regulation of employer-sponsored benefits programs and to eliminating regulatory proposals that impose unnecessary burdens, liabilities and costs on employers that elect to sponsor benefit plans.

The Health Insurance Association of America ("HIAA") is based in Washington, D.C., and is one of the largest associations of health insurance companies in the world. HIAA comprises more than 290 members which provide insurance for medical expenses, long-term care, and disability to more than 123 million Americans. HIAA advocates a private, market-based health insurance system and is dedicated to promoting federal and state health care policies that maximize the quality, affordability, accessibility, and responsiveness of medical services provided to the nation's health care consumers.

STATEMENT

1. Petitioner Rush Prudential HMO, Inc. ("Rush") is a health maintenance organization ("HMO") that contracts with employers and others to provide services to employee welfare benefit plans governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq*. In this particular case, Rush contracted with an employer to provide coverage for medical and hospital care to subscribing employees on a prepaid basis. Under the terms of the controlling ERISA plan document, Rush was obliged to provide coverage only for services that it determined to be "medically necessary," as that term was defined by the ERISA plan, and was afforded "the broadest possible discretion" to make those determinations. *Moran*, 230 F.3d at 962.

Respondent Deborah C. Moran was covered as a spouse under the ERISA plan to which Rush provided services. *Moran*, 230 F.3d at 962. In 1996, Moran sought treatment

for "pain, numbness, loss of function, and decreased mobility in her right shoulder" from Dr. Arthur LaMarre, a Rush-affiliated primary care physician, who treated Moran with physiotherapy and other conservative approaches. *Id.* When those efforts did not relieve her symptoms, Moran requested an out-of-network referral to be examined by Dr. Julia Terzis, a thoracic surgeon in Virginia who specializes in neuromuscular disorders. After Rush denied that request, Moran traveled to Virginia on her own accord to see Dr. Terzis, who diagnosed Moran with a nerve compression abnormality called thoracic outlet syndrome ("TOS"). Dr. Terzis recommended that Moran undergo a form of microneurolysis surgery that, all parties have conceded, is more complicated than the operation ordinarily performed on patients afflicted by TOS. *See id.* at 963-65.

Upon her return, Moran requested Rush to precertify the surgery Dr. Terzis had proposed. Although Dr. LaMarre concluded that the proposed surgery was "medically necessary," Rush denied coverage on the ground that it would be provided by an out-of-network physician. On Moran's appeal of that decision, and pursuant to its internal grievance procedure, two Rush-affiliated thoracic surgeons examined Moran and concluded that the procedure Dr. Terzis had proposed was not medically necessary because Moran required *standard* TOS surgery. After reviewing those surgeons' reports and conducting its own analysis of the relevant medical literature, Rush affirmed the coverage denial. *See id.* at 964.

2. Section 4-10 of the Illinois Health Maintenance Organization Act (the "Act"), 215 ILL. COMP. STAT. 125/4-10, provides that in the event of a dispute between a primary care physician and an HMO "regarding the medical necessity of a covered service proposed by [the] primary care physician," the HMO must "provide a mechanism for the timely review" of the dispute by an independent physician. Enacted in response to citizen complaints about the cost-containment practices of managed care companies, the Act provides that in the event the reviewing physician determines the covered service

to be "medically necessary," the HMO "*shall* provide the covered service." *Id.* (emphasis added).[2]

Following the final administrative denial of her coverage request, Moran served Rush with a written demand to appoint an independent physician pursuant to Section 4-10. *See Moran*, 230 F.3d at 965. Before Rush responded to the demand, Moran elected to undergo the surgery Dr. Terzis had proposed—a procedure that, including post-operative care, cost $98,841.27. Moran submitted the bill for the operation to Rush, which treated her submission as a renewed request for benefits and asked three medical experts, including the

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[2] Section 4-10 was enacted in Public Act 85-20 (eff. July 20, 1987). In the floor debate in the House of Representatives, Representative Shaw, a principal sponsor of the bill, explained that it "addresses several concerns which has [sic] been expressed concerning the operation of health maintenance organizations over the last year in Illinois." Transcription Debate, 85th General Assembly, 67th Legislative Day (June 24, 1987) at 233. "[T]he patient complaint and grievance procedure. And I think, from what I've heard around the state, the many patients, when they was [sic] involved in an HMO, they had nowhere to go and this was one of the things that they protested vigorously about, and I think it's this type of procedure that needs to be set forth." *Id.*; *see also id.* at 233-34 ("if they can't agree on the second opinion, then a third opinion is provided, and that opinion is binding * * * * [I]t doesn't solve all the problems that's dealing with HMO [sic], but I think that this is a milestone in legislation that the people of Illinois can live with and I ask for its adoption").

Illinois recently enacted an even more comprehensive "external review" provision as part of the Managed Care Reform and Patient Rights Act, P.A. 91-617 (eff. Jan. 1, 2000), codified at 215 IL. COMP. STAT. 134/1 *et seq*. The statute applies to HMOs (*see* 215 IL. COMP. STAT. 125/5-3.6), and thus imposes additional procedural requirements on them. Unlike Section 4-10, the Patient Rights Act does not limit external review to circumstances in which a primary physician and HMO disagree over whether treatment is "medically necessary." It applies to virtually all "medical necessity" determinations, as well as to coverage decisions about hospital stays and referrals to specialists. *See* 215 IL. COMP. STAT. 134/45(e). The Patient Rights Act also establishes precise timetables for completion of the independent review and expressly requires the plan to pay the fees of the external reviewer. *See* 215 IL. COMP. STAT. 134/50(f).

Chief of Plastic and Reconstructive Surgery at Washington University School of Medicine in St. Louis, to review her medical file. When none of those experts concluded that the surgery performed by Dr. Terzis was medically necessary, Rush again denied Moran's claim. *Moran*, 230 F.3d at 965.

Undeterred by the second denial of her claim for benefits, Moran filed a complaint against Rush in the Circuit Court of Cook County seeking "specific performance" of the independent review provision in Section 4-10. Over Rush's objection, the Circuit Court ordered Rush to submit Moran's claim to an independent reviewer, and Rush and Moran agreed to have the independent review conducted by Dr. A. Lee Dellon of Johns Hopkins Medical Center. Like the Rush-affiliated thoracic surgeons who had examined Moran, Dr. Dellon concluded that he would have performed a much less intrusive and time consuming procedure, but he nonetheless opined that the surgery performed by Dr. Terzis had been "medically necessary." *Moran*, 230 F.3d at 965.

3. Citing Dr. Dellon's findings, Moran amended her state court complaint to seek "reimbursement" from Rush for the costs of her operation. Because Moran's amended claim was in effect a claim for plan benefits—a claim that already had been twice denied pursuant to Rush's internal plan procedures—Rush then removed the complaint to federal court. *See Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 63-64 (1987) (holding that the exclusivity of the remedies provided by ERISA § 502(a), 29 U.S.C. § 1132(a), permits removal). Moran moved to remand the action to state court on the ground that her suit was predicated on a state law that regulated insurance within the meaning of ERISA's "saving clause," 29 U.S.C. § 1144(b)(2)(A).

The district court first addressed Moran's motion to remand and concluded that her Section 4-10 cause of action was preempted by ERISA § 502(a). Pet. App. 41a. "Regardless of how she characterizes it," the district court explained, "Moran's current claim is a § 502(a) denial of benefits claim" because it contests "Rush['s] refusal to reimburse her for the

treatment" rendered by Dr. Terzis. *Id.* The district court rejected Moran's claim that Section 4-10 was saved from preemption by ERISA's insurance saving clause, ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A), reasoning that Section 4-10 does not regulate insurance because it does not spread or transfer risk or "affect the disbursement of benefits * * * to all [Rush subscribers] * * * or mandate or deny a certain class of benefits." Pet. App. 42a (citing *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 744 (1985)). Finding no abuse of discretion in the denial of Moran's claim, the district court entered summary judgment for Rush.

4. The Seventh Circuit reversed. Although agreeing that removal had been proper because "Moran's state law claims are properly recharacterized as claims for benefits under § 502(a)(1)(B) of ERISA" (*Moran*, 230 F.3d at 967), the court of appeals concluded that Rush had abused its discretion in denying Moran's claim for reimbursement. As the court of appeals saw the issue, Rush was obliged to comply with the "independent review of Dr. Dellon" (*id.* at 965), because Section 4-10 had become part of Moran's contract with Rush "by operation of [Illinois] law." *Id.* at 969 ("[Statutory] provisions * * * are substantive terms of all insurance policies in Illinois by operation of law").

The court of appeals rejected Rush's contention that Section 4-10 was preempted by ERISA. In particular, the court of appeals rejected Rush's claim that Section 4-10 is an alternative enforcement mechanism to Section 502(a) that is preempted by the teaching of *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987). Notwithstanding its recognition that Section 4-10 "establishes an additional * * * mechanism for making decisions about medical necessity" that adds "an additional dispute resolving mechanism" to the plan (*Moran*, 230 F.3d at 972), the court of appeals concluded that because Section 4-10 had been "incorporated into * * * Moran's insurance contract" by operation of Illinois law, it could "not be characterized as creating an alternative remedy scheme that conflicts with § 502(a)." *Id.* Rather, Moran's suit was "simply a suit to enforce the terms of the plan." *Id.* (citing *UNUM Life*

Ins. Co. v. Ward, 526 U.S. 358, 377 (1999) ("*Ward*")). The court of appeals went on to explain that although Section 4-10 nonetheless "relate[d] to" an ERISA plan within the meaning of Section 514(a), 29 U.S.C. § 1144(a)—a point that Moran had in any event conceded (*see Moran*, 230 F.3d at 968)—it was saved from preemption as a law that regulates insurance under 29 U.S.C. § 1144(b)(2)(A). *Id.* at 969.

The court of appeals expressly noted that its decision conflicted with the Fifth Circuit's decision in *Corporate Health Ins., Inc. v. Texas Dep't of Ins.*, 215 F.3d 526 (5th Cir. 2000) (holding that Texas' external review statute was preempted by ERISA because it established an "alternative enforcement mechanism" to Section 502), *on reh'g*, 220 F.3d 641 (same), *petition for cert. filed sub nom., Montemayor v. Corporate Health Ins., Inc.*, No. 00-665 (Oct. 24, 2000) ("*Montemayor*"). The court of appeals concluded, however, that the Fifth Circuit had erred in holding that a state independent review law "creates an alternative mechanism through which plan members may seek benefits due them under the terms of the plan," *Montemayor*, 215 F.3d at 539. According to the court of appeals, such statutes "simply add[] to the contract, by operation of law," and therefore a suit to enforce them is nothing more than a suit "to enforce the terms of the plan." *Id.* at 970; *see also Moran*, 230 F.3d at 971 (the "'sole launching ground' for Ms. Moran's claims to enforce § 4-10 * * * remains § 502(a)") (quoting *Ward*, 526 U.S. at 377).

5. Judge Posner, joined by Judges Coffey, Easterbrook, and Diane P. Wood, dissented from the denial of rehearing *en banc*. Judge Posner characterized the panel's decision as "startling" and noted that Section 4-10 is plainly preempted by ERISA because it "establishes a system of appellate review of benefits decisions that is distinct from" Section 502(a) and thus "interferes with the federally specified system for enforcing" plan benefits. 230 F.3d at 973-74. Judge Posner also dismissed as a "*façon de parler*" the panel's view that Section 4-10 somehow was incorporated into the terms of Moran's plan by operation of law. *Id.* at 973. Not only

does that approach "invite[] states to evade [ERISA's] preemptive force * * * simply by deeming its regulations of ERISA plans to be plan terms," he observed, but it suffers from a logical inconsistency: if the plan "merely regulates insurance and therefore is not preempted," it cannot "be part of an ERISA plan and enforceable in federal court." *Id.* at 973-74.

Judge Posner also explained that the panel's reliance on *Ward* was misplaced because *Ward* saved from preemption a state law that "was a typical regulation of insurance rather than anything either special to ERISA plans or likely to be mischievous in its impact on those plans." 230 F.3d at 973. Indeed, "[f]ar from being compelled by [*Ward*], the panel's opinion is in tension with *Pegram v. Herdrich*, 530 U.S. 211 (2000)," a decision which—unlike the panel's—"did not doubt that ERISA applied to HMO-managed ERISA plans." *Id.* Judge Posner cautioned that the panel's decision would "add[] heavy new procedural burdens to ERISA plans" and "undermine[] the * * * federal uniformity in the administration" of employee benefit plans that ERISA was enacted to ensure. *Id.*

SUMMARY OF ARGUMENT

The judgment of the court of appeals cannot be reconciled with the consistent course of this Court's ERISA cases, all of which make clear that the civil enforcement provisions in ERISA § 502(a) are exclusive and preempt state laws that purport to authorize alternative avenues of relief. Because Section 4-10 unquestionably establishes an "alternative enforcement mechanism" (*New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 658 (1995)) to the remedies provided in section 502(a), it is preempted by ERISA §§ 502(a) and 514(a).

The court of appeals erred in concluding that Section 4-10 is saved from preemption as a law regulating insurance. In *Pilot Life v. Dedeaux*, 481 U.S. 41 (1987), this Court unanimously held that state laws that establish alternative enforcement mechanisms to section 502(a) do *not* constitute

laws that "regulate insurance" within the meaning of ERISA's saving clause. *Pilot Life* not only stands for the proposition that Section 502 remedies preempt conflicting state laws under conventional conflict preemption principles. It made clear that the exclusivity of Section 502 remedies is so important to ERISA's design that it must inform judicial interpretation of the scope of the business of "insurance" that Congress intended to reserve for the States. Because "the role of the saving clause in ERISA as a whole" demonstrates that it was not intended to save state laws that purport to "supplement[] or supplant[]" the exclusive remedies that Congress made available in Section 502(a) (*Pilot Life*, 481 U.S. at 56), the alternative remedy provided by Section 4-10 cannot be saved under that provision.

In any event, Section 4-10 does not constitute a law that regulates insurance from "a common sense view of the matter" (*UNUM Life Ins. Co. v. Ward*, 526 U.S. 358, 367 (1999)), or as measured by the three McCarran-Ferguson Act guideposts. Section 4-10 is not directed at insurance or the insurance industry, but at HMOs. The law does not spread or transfer risk, it is not integral to the policy relationship between an insurer and insured, and it does not affect only entities in the insurance industry. Whatever else it may be, Section 4-10 is not a law that regulates insurance within the meaning of ERISA's saving clause. The judgment of the court of appeals must be reversed.

ARGUMENT

ILLINOIS' STATUTE IS CLEARLY PREEMPTED BY ERISA BECAUSE IT CONFLICTS WITH SECTION 502(A) AND IS NOT SAVED FROM PREEMPTION BY THE INSURANCE SAVING CLAUSE.

Illinois' independent review requirements purport to establish a binding enforcement mechanism for claimants who are dissatisfied with the health benefits provided by their HMOs. Those requirements constitute precisely the sort of alternative state law remedy that Congress intended to preempt with Section 502(a)'s comprehensive remedial scheme.

A. Illinois' Statute Constitutes An Alternative Enforcement Mechanism Preempted By Sections 502(a) And 514(a).

1. Section 514(a) of ERISA preempts State laws "insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). Although this Court has cautioned that "the term 'relate to' cannot be taken 'to extend to the furthest stretch of indeterminacy,' or else 'for all practical purposes pre-emption would never run its course,'" *Egelhoff v. Egelhoff*, 121 S. Ct. 1322, 1327 (2001) (quoting *Travelers*, 514 U.S. at 655), this Court's cases make clear that state laws unquestionably are preempted to the extent they purport to authorize "alternative enforcement mechanisms" (*Travelers*, 514 U.S. at 658) to the exclusive remedial provisions set forth in Section 502 of ERISA, 29 U.S.C. § 1132.

That principle was established in this Court's unanimous decision in *Pilot Life*, which held that state-law contract and tort claims filed against an insurer for the "bad faith" denial of certain disability benefits under an ERISA plan were preempted by section 514(a). *Pilot Life*, 481 U.S. at 55-56. Although the tort of "bad faith" had long been used to seek damages for wrongful benefits denials, the Court concluded that permitting such a cause of action would amount to giving plan beneficiaries an alternative enforcement mechanism for contesting the denial of ERISA benefits. *Id.* at 54, 57. As the Court explained, any state-law cause of action that amounts to such an alternative enforcement action is preempted by ERISA, because Congress clearly intended for the remedies set forth in ERISA § 502(a), 29 U.S.C. § 1132(a), to be exclusive:

> The six carefully integrated civil enforcement provisions found in § 502(a) of the statute * * * provide strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly.

Id. at 54 (emphasis in original). The Court explained that Congress' decision to make the remedial provisions of Section 502(a) exclusive "would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain [alternative] remedies under state law[.]" *Id.*

On the same day it decided *Pilot Life*, this Court held that the preemptive effect of ERISA's civil enforcement provisions is so strong and complete that an ERISA preemption defense under section 502(a) provides a sufficient basis to remove a state cause of action to a federal forum, notwithstanding the traditional limitation imposed by the well-pleaded complaint rule. *See Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 63-64 (1987). Like *Pilot Life*, *Taylor* made clear that respect for the exclusivity of ERISA's civil enforcement scheme is essential "to ensure that plans and plan sponsors [are] subject to a uniform body of benefits law," *Travelers*, 514 U.S. at 656, and that state laws that interfere with that enforcement scheme—and *especially* state laws that provide *alternatives* to it—are preempted by *both* sections 514(a) and 502(a). *Taylor*, 481 U.S. at 64.

The Court reiterated and extended those principles in *Ingersoll-Rand v. McClendon*, 498 U.S. 133 (1990). There, the Court held that ERISA preempted a state wrongful discharge cause of action predicated on an employee's allegation that he had been terminated to prevent his plan benefits from vesting. Relying on *Pilot Life* and *Taylor*, the Court concluded that McClendon's claim was preempted by Section 514(a) and ordinary "requirements of conflict preemption," because McClendon's state-law claim purported "to provide a remedy for the violation of a right expressly guaranteed by [ERISA] and exclusively enforced by Section 502(a)." *Id.* at 144. The Court explained that "'when it is clear or may fairly be assumed that the activities which a State purports to regulate are protected by * * * [ERISA], due regard for the federal enactment requires that state jurisdiction must yield.'" *Id.* (quoting *Lingle v. Norge Div. of Magic Chef, Inc.*, 486 U.S. 399, 409 n.8 (1988)).

2. There can be no dispute that under those precedents Section 4-10 constitutes an impermissible alternative state-law remedy to recover plan benefits that goes beyond the exclusive remedies set forth in Section 502(a). As Judge Posner recognized in his dissent from the denial of rehearing *en banc* below, Illinois' "law establishes a system of appellate review of benefits decisions that is distinct from the provision in ERISA for suits in federal court to enforce entitlements conferred by ERISA plans." 230 F.3d at 973. The Fifth Circuit in *Montemayor* also had little trouble concluding that Texas' external review statute "establish[es] a quasi-administrative procedure for the review of [benefits] denial[s]" and thus "creates an alternative mechanism through which plan members may seek benefits due them." *Montemayor*, 215 F.3d at 539.

The Seventh Circuit attempted to evade that conclusion by treating Section 4-10 as a permissible "mandated contract term" that became part of the ERISA plan—and thus enforceable in an action under Section 502(a)—by operation of state contract law. *Moran*, 230 F.3d at 969 ("[Illinois'] statutory provisions enter into and form a part of all contracts of insurance" in the State). In support of that characterization of the state statute, the court of appeals cited *Ward*, which held that California's notice-prejudice rule was saved from preemption as a law regulating insurance, and *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), which held that a state law mandating mental health benefits was not within ERISA's preemptive reach. *See* 230 F.3d at 969-70.

Neither *Ward* nor *Metropolitan Life* supports the proposition that States may evade preemption under ERISA simply by adopting a rule that purportedly incorporates state statutes into any benefits plan "by operation of law." *Metropolitan Life* involved a mandated benefit—a substantive coverage requirement—not any remedy beyond those enumerated in ERISA § 502, and the Court did not advert to any Massachusetts doctrine that incorporates state statutes into insurance contracts "by operation of law" or otherwise. *See* 471 U.S. at

741. Although *Ward* did state that the notice-prejudice rule "*effectively* create[d] a mandatory contract term" (*Ward*, 526 U.S. at 374) (emphasis added), it did not base that conclusion on the existence of any California doctrine requiring the incorporation of state insurance laws into insurance contracts. Read in context, that statement merely reflected the Court's conclusion that because the state law was saved from preemption, it was "effectively" binding on the plan. *Id.* at 375-76.

At most, *Ward* and *Metropolitan Life* stand for the proposition that a state-law requirement may "effectively" (*Ward*, 526 U.S. at 374) be considered a term of an ERISA plan if it does not otherwise conflict with ERISA's substantive provisions or stand as an obstacle to the accomplishment of ERISA's objectives. Neither decision, however, purports to establish a principle that would permit States to enact alternative enforcement mechanisms to Section 502(a) simply by deeming those mechanisms to be provisions of the plan. Indeed, the panel's logic would permit the "transparent * * * evasion of ERISA's preemption clause," *Moran*, 230 F.3d at 972-74 (Posner, J., dissenting from denial of reh'g *en banc*), because States could evade Section 514(a)'s preemptive reach entirely through the simple artifice of declaring their laws "incorporated" into plan documents. By that logic, a state law that required all coverage determinations to be reviewed by a state "board of HMO review," or a state law that purported to require HMOs to pay subscribers compensatory and punitive damages in the event an "independent reviewer" determined the plan had denied coverage in "bad faith," would be saved from preemption, because a suit to enforce those requirements would not be an impermissible "alternative enforcement mechanism" (*Travelers*, 514 U.S. at 658), but rather a suit "to enforce rights and to recover benefits *under the plan*." *Moran*, 230 F.3d at 971 (emphasis added). *Ward*'s description of the notice-prejudice rule as a "mandated contract term" simply cannot be stretched so far as to stand for a rule of law that would completely eviscerate ERISA preemption whenever States deem preemption incon-

venient. *See Citizens Bank of Maryland v. Strumpf*, 516 U.S. 16, 20 (1995) ("It is an elementary rule of construction that the act cannot be held to destroy itself.")[3]

Moreover, the Seventh Circuit's "mandated contract term" analysis is inconsistent with *Ingersoll-Rand*, which makes clear that a state law must be viewed as an impermissible alternative enforcement mechanism whenever it "purports to provide a remedy for the violation of a right expressly guaranteed by [ERISA's substantive provisions]" (*Ingersoll-Rand*, 498 U.S. at 145), and with *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), which holds that federal courts must give deferential review to benefits determinations whenever plan documents give administrators discretionary authority over those determinations, *id.* at 110-15. Respondent's cause of action under Section 4-10 seeks recovery of no more (and no less) than the benefit to which she is entitled under her plan: coverage for "medically necessary" care. Section 4-10, however, essentially eliminates "the broadest possible discretion" that plan documents expressly confer on Rush, and thus the statute compels federal courts simply to enforce, without further inquiry, the judgment of the state-law "reviewer." There can be no doubt that Section 4-10 is not a "mandated contract term," but an alternative "launching ground for an ERISA enforcement action." *Ward*, 526 U.S. at 377.[4]

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[3] Under the panel's analysis, whether state external review statutes constitute "alternative enforcement mechanisms" will apparently depend entirely on the vagaries of state contract law. For example, under Texas law, which was at issue in *Montemayor*, not every law is incorporated into every contract of insurance. *See Jun v. Lloyds*, No. 37 S.W.3d 59 (Tex. App.—Austin, 2000, pet. denied).

[4] The Secretary of Labor recently promulgated regulations pursuant to Section 503. *See* 65 Fed. Reg. 70246 (November 21, 2000) (eff. January 20, 2001) (applicable to claims filed on or after July 1, 2002 but not later than January 1, 2003 (*see* Claims Procedure; Notice of Extension of Applicability Date, 66 Fed. Reg. 35885 (July 9, 2001)). Although the new claims processing procedures prescribed by the new regulations do not purport to preempt State "external review" laws, those regulations nonetheless make clear that the Secretary does not share the Seventh Circuit's view that external review laws are simply mandated plan terms. *See* 29 C.F.R. §§ 2950(k)(i)-(ii). That is because the regulations provide that a beneficiary need not exhaust remedies under those State laws before initiating a suit for benefits under Section 502. *See id.* Given the well-settled rule requiring plan beneficiaries to exhaust their plan remedies before initiating suit under Section 502 (*see Ravencraft v. UNUM Life Ins. Co. of Am.*, 212 F.3d 341, 343 (6th Cir. 2000), the Secretary of Labor obviously believes that State external review requirements cannot reasonably be viewed as an additional plan remedy, but rather amount to alternative enforcement mechanisms. *See* 65 Fed. Reg. at 70254 ("[I]n the Department's view, th[ose] [State laws] are not part of the claims procedures contemplated by Section 503 of the Act, but are 'external reviews' that are beyond the scope of the regulation.").

3. Illinois' external review statute not only creates an alternative enforcement mechanism forbidden by *Pilot Life* and its progeny, but also would, if permitted to survive ERISA preemption, frustrate Congress' aim of "avoid[ing] a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." *Travelers*, 514 U.S. at 657. As this Court explained in *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987):

> An employer that makes a commitment systematically to pay certain benefits undertakes a host of obligations, such as determining the eligibility of claimants * * * [and] making disbursements * * * The most efficient way to meet these responsibilities is to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits. Such a system is difficult to achieve, however, if a benefit plan is subject to differing regulatory requirements in differing States. A plan would be required to * * * process claims in a certain way in some States but not in others * * *

Id. at 9.

[Footnote continued from previous page]

Validation of Illinois' external review law or similar laws enacted by other States would clearly frustrate Congress' goal of "secur[ing] national uniformity in the administration of employee benefit plans," *Boggs v. Boggs*, 520 U.S. 833, 842 (1997), because plan administrators would be required to make benefits determinations—a central concern of ERISA—under statutory regimes that not only vary from one state to the next, but also potentially subject administrators to overlapping or inconsistent external review requirements. Indeed, several states—California, Maryland, and Virginia, for example—apparently would apply their external review procedures to any contract concluded in their state, even if that contract governs the availability of benefits to subscribers that may reside (and receive medical treatment) elsewhere, and even if the state where the subscriber resides has adopted some other approach to external review.[5] A result more antithetical to Congress' policy could scarcely be imagined.

[5] *Compare* MD. CODE ANN. § 15-10A-01.1 (external review process "applies to a health benefit plan that: (1) is delivered or issued in the State; or (2) covers individuals who reside or work in the State * * *"); CAL. HEALTH & SAFETY CODE § 1374.30(3) (external review requirements apply to "[e]very health care service plan contract that *is issued, amended, renewed, or delivered in this state* on or after January 1, 2000") (emphasis added); VA. CODE ANN. §§ 38.2-5901(A), 32.1-137.7 (independent review provisions apply to "a subscriber [or] policyholder * * * under a policy or contract *issued or issued for delivery in Virginia* by a managed care health insurance plan") (emphasis added); *with* AZ. STAT. § 20-2531 ("[T]his article applies to all utilization review decisions made by * * * health care insurers operating in this state"); KAN. STAT. ANN. § 40-22a04 (external review provisions apply to "utilization review services in this state or affecting residents of this state").

B. Illinois' Statute Is Not Saved From Preemption By The Insurance Saving Clause, Because Alternative Enforcement Mechanisms To Section 502(a) Are Not Laws That Regulate Insurance.

The conclusion that Section 4-10 constitutes an "alternative enforcement mechanism" to Section 502 forecloses respondent's claim that Section 4-10 is saved from preemption under ERISA's "saving" clause, 29 U.S.C. § 1144(b)(2)(A). In *Pilot Life*, this Court unanimously held not only that the remedies set forth in Section 502 were intended to be exclusive and thus preemptive of conflicting state laws under ordinary conflict preemption principles. It *also* held that the exclusivity of Section 502 informed interpretation of the "saving" clause. *See* 481 U.S. at 52. Indeed, the Court explained that Section 502(a)'s exclusive remedial scheme was the "most important[]" factor indicating that the state law was not the business of "insurance" that Congress intended to preserve for State regulation. *Pilot Life*, 481 U.S. at 52. *Pilot Life* thus stands for the proposition that the insurance saving clause will not save from preemption state laws that "supplement[] or supplant[]" the exclusive remedies that Congress made available under Section 502(a). *Id.* at 56.

1. Respondent contends, however, that Illinois' law should be invalidated under the saving clause only if "it would be impossible to comply with the state * * * regulation and ERISA" (Resp. Br. Opp. at 8).[6] Respondent places primary reliance on the statement in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), "declin[ing] to im-

[6] Respondent's argument is similar to the position taken by the United States in *Ward*. There, the Solicitor General suggested that ERISA's saving clause may save from preemption state insurance laws that conflict with the exclusive remedies provided by Section 502 of ERISA—even though his reasoning to the contrary had been adopted by a unanimous Court in *Pilot Life* (*see Pilot Life*, 481 U.S. at 52). *See* Br. of United States as *Amicus Curiae* in *Ward*, No. 97-1868 (filed November 1998), at 22-25.

pose any limitation on the saving clause beyond those Congress imposed in the clause itself." *Id.* at 746. Respondent reads that statement as requiring the Court to "[give] effect to the facially unrestricted scope of the insurance savings clause." *See* Resp. Br. in Opp. at 8. But as the Court expressly recognized in *Pilot Life*, "*Metropolitan Life* * * * did *not* involve a state law that conflicted with a substantive provision of ERISA." *Pilot Life*, 481 U.S. at 57 (emphasis added). Because Section 4-10 *does* conflict directly with the exclusivity of the remedies provided by Section 502(a), it is clearly preempted, by virtue of *Pilot Life*, even under respondent's own "conflict" test.

In any event, respondent is wrong to suggest that Section 4-10 is not preempted unless it makes "compliance with both state and federal law * * * impossible," *California v. ARC America Corp.*, 490 U.S. 93, 100 (1989). As this Court has recognized repeatedly since *Pilot Life* was decided, ERISA's preemptive reach extends to state laws—and even to state *insurance* laws—that stand as an obstacle to accomplishment of ERISA's objectives. *See John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86, 99 (1993) ("where [state insurance] law stands as an obstacle to the accomplishment of the full purposes and objectives of Congress, federal preemption occurs"); *see also Boggs*, 520 U.S. at 844 ("Conventional conflict pre-emption principles require pre-emption where compliance with both federal and state regulations is a physical impossibility, * * * or where state law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.").

Moreover, whatever force the arguments advanced by respondent here (and the Solicitor General in *Ward*) may have, those arguments are plainly insufficient to justify reconsideration of *Pilot Life*'s holding that Section 502(a) pre-empts *all* state statutes that establish alternative enforcement mechanisms to Section 502(a), including those that would otherwise fall within the saving clause if Section 502(a) did not inform the scope of "insurance" that Congress intended to reserve for the States. This Court has recognized the high

burden that must be "borne by the party advocating the abandonment of an established precedent," especially where, as here, "the Court [may be] asked to overrule a point of statutory construction." *Patterson v. McLean Credit Union*, 491 U.S. 164, 172 (1989). That burden simply has not and cannot be met here.

None of the factors historically regarded as necessary to overturn a settled statutory interpretation is present here. There has been no "intervening development of the law" (*Patterson*, 491 U.S. at 173), casting doubt on that (or any) aspect of *Pilot Life*'s holding. To the contrary, the Court has repeatedly reaffirmed *Pilot Life* in a variety of contexts. *See Ingersoll-Rand*, 498 U.S. at 135; *Taylor*, 481 U.S. at 62-63. Nor has the rule of *Pilot Life* constituted an "obstacle" to important federal purposes or proved "inconsistent with the sense of justice or with the social welfare." *Patterson*, 491 U.S. at 174. Quite to the contrary, the number of employee welfare benefit plans has exploded in recent years, extending pension, disability, and health care coverage to more workers than ever before, largely, if not primarily, because of the certainty and predictability effected by this Court's holding in *Pilot Life*. *See* Paul Fronstin, *Employment-Based Health Benefits: Trends and Outlook*, Issue Brief No. 233, Employee Benefit Research Institute (May 2001) (noting sharp increase in number of employees covered by employer-sponsored health plans since 1994); U.S. DEP'T OF COMMERCE, BUREAU OF THE CENSUS, STATISTICAL ABSTRACT OF THE UNITED STATES at 383, 535 (115th ed. 1995) (noting rapid growth of employee welfare benefit plans). Employers who adopted welfare benefit plans did so on the understanding that "the regulation of employee welfare benefit plans [w]as exclusively a federal concern." *Travelers*, 514 U.S. at 656; *see also Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981). To unsettle those expectations by revisiting *Pilot Life* at this late date could scarcely fail "to deter some employers from offering health insurance at all." *Moran*, 230 F.3d at 973-74 (Posner, J., dissenting from denial of reh'g *en banc.*); *see also Fort Halifax*,

482 U.S. at 11 (narrowly construing ERISA's preemptive effect could cause "those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them").

Moreover, the interest in stability and predictability in the law strongly counsels against revisiting any aspect of *Pilot Life*. This Court has recognized that issues of ERISA preemption have "generated an avalanche of litigation in the lower courts." *De Buono v. NYSA-ILA Medical and Clinical Serv. Fund*, 520 U.S. 806, 808 n.1 (1997). The Court itself has decided 18 cases (the Court identified 16 in *De Buono* and since then has decided *Egelhoff* and *Ward*), and several of those were split and deeply fractured opinions. *See, e.g.*, *Boggs*, 520 U.S. at 833, 854; *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 841 (1988); *Fort Halifax*, 482 U.S. at 1, 22. This Court's unanimous opinions in *Pilot Life*, *Ingersoll-Rand*, and *Taylor* speak with an unmistakable clarity that over the long run has redounded to the benefit of plan participants and administrators alike. No compelling reason exists to revisit what has become a cornerstone—and perhaps the only clear, unambiguous rule—of this Court's ERISA jurisprudence. Section 4-10 constitutes an alternative enforcement mechanism and is accordingly preempted under *Pilot Life*, whether or not it otherwise might be said to regulate "insurance" under the alternative—and untested—world-view championed by respondent and the State in this case.

C. In Any Event, Illinois' Statute Does Not Regulate Insurance As A Common Sense Matter Or As Measured Under The Three McCarran-Ferguson Guideposts.

In any event, respondent's contention that Section 4-10 is a law regulating insurance within the meaning of ERISA's saving clause is meritless on its own terms. Section 4-10 is a regulation of HMOs, not insurance, and it expressly regulates HMOs when they are acting in purely administrative capacities. Thus, even assuming *arguendo* that in some circumstances a state law alternative remedy might escape *Pilot Life*'s preemptive reach, Section 4-10 is not saved from preemption here.

1. This Court's decisions in *Ward* and *Metropolitan Life* establish a framework for determining whether a law regulates insurance within the meaning of the saving clause. First, the court must determine "whether, from a 'common-sense view of the matter,' the contested prescription regulates insurance." *Ward*, 526 U.S. at 367 (quoting *Metropolitan Life*, 471 U.S. at 740). The court next must consider "three factors employed to determine whether the regulation fits within the 'business of insurance' as that phrase is used in the McCarran-Ferguson Act." *Ward*, 526 U.S. at 367. Those factors are "first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and insured; and third, whether the practice is limited to entities within the insurance industry." *Ward*, 526 U.S. at 367; *Metropolitan Life*, 471 U.S. at 743.

The court of appeals erred in concluding that Section 4-10 regulates insurance from a "common-sense view of the matter." The court of appeals believed that Section 4-10 "is directed at the HMO industry *as insurers*." *Moran*, 230 F.3d at 969 (emphasis added). That conclusion, however, is belied by the definition of "HMO" in the Illinois Act, which includes any organization that performs services as part of any arrangement "which causes *any part* of the risk of health care delivery to be borne by the organization *or its providers*." 215 ILL. COMP. STAT. 125/1-2(9) (emphasis added). That definition covers not only HMOs that fully insure the risk of health care delivery, but also applies to HMOs that perform purely *administrative* services for self-funded plans, a fact that destroys any attempt by the State to rely on the saving clause under this Court's precedents. *See FMC Corp. v.*

Holliday, 498 U.S. 52, 61 (1990) (discussing "deemer" clause).[7]

For example, when HMOs contract to provide purely administrative services to self-funded plans, they frequently provide plan subscribers with access to networks of physicians credentialed by, and affiliated with, the HMO. HMOs contract with those physician networks in a multiplicity of forms, including "staff model," "group model," and "IPA model" arrangements.[8] Several of those arrangements involve payments to physicians on a "capitated" basis—*i.e.*, an agreement to pay physicians "[a] set amount of money * * *

[7] Texas' independent review statute also applies to HMOs that perform purely administrative services for *self-funded* plans. *See* TEX. INS. CODE ANN. art. 21.58, §§ 2(17)(B) and (C), 2(21)(B), 6 and 6A (independent review requirements apply to "*any* * * * person or entity which * * * *administers* * * * health benefits * * * pursuant to a policy, plan, or contract") (emphasis added).

[8] In a "staff model," the HMO "directly employs staff physicians and compensates them as salaried employees." Diana J. Bearden & Bryan J. Maedgen, *Emerging Theories Of Liability In The Managed Care Industry*, 47 Baylor L. Rev. 285, 292 (1995). The physicians are employees of the plan and make coverage decisions on behalf of the plan. The HMO at issue in *Pegram* was a "staff model" HMO. *See Pegram*, 530 U.S. at 215-17.

In a "group model," the HMO "contracts with a group of physicians (typically an incorporated group practice), rather than individual physicians, to devote all or much of its time to providing care to HMO members at the group's clinic and facilities for a fixed monthly fee per covered individual." Bearden & Maedgen, *supra*, 47 Baylor L. Rev. at 292-93. "The fixed per-member monthly fee is * * * referred to as a 'capitation rate.'" *Id.* at 293.

In an "IPA model," the HMO "contracts with an independent practice association, which is usually a partnership or corporation comprised of various independent practicing physicians. The association, in turn, contracts directly with each of its independent physicians with respect to terms and conditions of participation, including the method of payment." *Id.* The HMO "pays the IPA a specified capitation amount and the IPA, in turn, pays the participating physicians on a fee-for-service" or capitated basis. *Id.*

based on membership [numbers] rather than on services delivered." Peter R. Kongstvedt (ed.), THE MANAGED HEALTH CARE HANDBOOK at 988 (3d ed. 1996). Regardless of the quantity of services provided, therefore, the physicians' compensation is fixed, and thus the *providers—not* the HMO—bear "part" of "the risk of health care delivery" under the plain terms of the Illinois' statute. *See* Frank T. Herdman, *Doctors, Insurers, And The Antitrust Laws*, 37 Buffalo L. Rev. 789, 807 (1988-89) ("The primary benefit of a capitation system to an HMO is that the risk of providing health services is no longer borne by the HMO.") Thus, although the HMO's purely administrative arrangement with the self-funded plan has the effect of transferring "the risk of health care delivery to * * * providers" (215 ILL. COMP. STAT. 125/1-2(9)), the HMO itself does not assume any risk—the *sine qua non* of the "insurance" business, *see Group Life & Health Ins. Co. v. Royal Drug Co. Inc.*, 440 U.S. 205, 212 (1979) ("*Royal Drug*").[9] The court of appeals' conclusion that Section 4-10 is aimed "directly at HMOs *as insurers*" (*Moran*, 230 F.3d at 969) (emphasis added) therefore is manifestly erroneous under the plain terms of the State's statute.

The conclusion that Section 4-10 does not regulate insurance from a "common-sense view of the matter" finds further support in the history of the regulation of prepaid health plans. In *Metropolitan Life*, the Court upheld the state-

[9] *See generally* Herdman, *supra*, 37 Buffalo L. Rev. at 806-17 (explaining that risk is ordinarily borne by providers in products offered by HMOs to employers). This Court has noted the difference between traditional indemnity insurance plans and HMOs in this regard. *See Arizona v. Maricopa County Medical Soc'y*, 457 U.S. 332, 339 n.7 (1982) ("An alternative to the fee-for-service type of insurance plan is illustrated by the health maintenance organizations authorized under the Health Maintenance Organization Act of 1973 * * * * Under this form of prepaid health plan, the consumer pays a fixed periodic fee to a functionally integrated group of doctors in exchange for the group's agreement to provide any medical treatment that the subscriber might need. *The economic risk is thus borne by the doctors.*") (emphasis added).

mandated benefit law at issue in large part on the ground that it had been historically regarded as a traditional insurance law. 471 U.S. at 742-43. That is manifestly *not* true with respect to prepaid health arrangements, such as HMOs. In *Royal Drug*, the Court recognized that States that regulated prepaid health-service plans at the time the McCarran-Ferguson Act was enacted "either exempted them from the requirements of the state insurance code or provided that they shall not be construed as being engaged in the 'business of insurance' under state law." 440 U.S. at 226 (quotation and citation omitted).[10] That fact is significant, for as this Court recognized in *Metropolitan Life*, "[t]he saving clause and McCarran-Ferguson Act serve the same federal policy and utilize similar language to define what is left to the States." 471 U.S. at 744 n.21. The contemporary understanding that prepaid health plans "were not engaged in providing insurance" (*Royal Drug*, 440 U.S. at 227) is highly significant in ascertaining whether Congress intended to reserve regulation of all HMO activities to the States.[11]

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10 "Advance-payment" health plans such as Blue Cross & Blue Shield, which contracted with subscribers to arrange for health services and hospital care on a prepaid basis (and which compensated physicians at negotiated rates), were the non-profit precursors to the modern for-profit HMO. *See generally* Robert I. Cunningham *et al.*, THE BLUES: A HISTORY OF THE BLUE CROSS AND BLUE SHIELD SYSTEM at 7-21, 210 (1997); Donald R. Levy (ed.), 2001 STATE BY STATE GUIDE TO MANAGED CARE (2001) at 1-3 ("A health maintenance organization is defined as a health plan that offers prepaid, comprehensive health coverage for both hospital and physician services.").

11 Indeed, only one year before it enacted ERISA, the 93d Congress enacted the Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, codified at 42 U.S.C. §300e *et seq.*, to establish requirements for the administration and management of federally-qualified HMOs—a substantial legislative undertaking entirely inconsistent with the proposition that Congress understood the regulation of HMOs to be the type of traditional regulation of "insurance" that Congress intended to reserve to the States. As two commentators have observed: "The purpose of the 1973 Act was to *prevent* state laws from impeding the development of HMOs. In particular, Congress was concerned that local physicians' political

Finally, the conclusion that external review statutes such as Section 4-10 are not directed at the business of insurance is further cemented by examination of the circumstances in which those statutes have been enacted. As Judge Posner recognized, external review statutes constitute state legislative responses "to the recent torrent of criticisms of HMOs." *Moran*, 230 F.3d at 974 (Posner, J., dissenting from denial of reh'g *en banc*). Because HMOs are "the service providers under a great many ERISA medical-benefits plans" (*id.* at 973), including countless self-funded plans that could not be reached by the States under any conceivable interpretation of ERISA, *see FMC Corp.*, 498 U.S. at 63, the problem the States purported to address was by definition *not* "grounded in policy concerns specific to the insurance industry." *Ward*, 526 U.S. at 372.

All of these considerations point to the conclusion that the Illinois external review statute does not regulate insurance from a "common-sense view of the matter." *Ward*, 526 U.S. at 367. "A common sense view of the word 'regulates' [means] * * * that in order to regulate insurance, a law must not just have an impact on the insurance industry, but must be specifically *directed* toward that industry." *Pilot Life*, 481

[Footnote continued from previous page]

clout with state regulators would prevent HMOs from developing as a more efficient means of delivering quality health care." Jeffrey W. Stempel & Nadia von Magdenko, *Doctors, HMOs, ERISA, And The Public Interest After* Pegram v. Herdrich, 36 Tort & Ins. L.J. 687, 734 n. 96 (2001) (emphasis added). The Senate Report to the bill that was ultimately enacted states unequivocally that "[i]n the committee's view HMOs * * * should not be required to submit to regulations as an insurer of health care services * * * * Such requirements would be unduly restrictive, onerous, and not within the spirit of this legislation * * * * " S. Rep. 93-129 *reprinted in* 1973 U.S.C.A.A.N. 3033, 3058 (1973). Indeed, the Report identifies "applicable state insurance laws and regulations" as one of the "[p]rincipal state legal barriers * * * to the development of HMOs." *See id.*; *see also Pegram*, 530 U.S. at 233 ("The fact is that for over 27 years the Congress of the United States has promoted the formation of HMO practices.").

U.S. at 50 (emphasis added). Section 4-10 does not remotely satisfy that standard.[12]

2. At the petition stage, respondent contended that Section 4-10 was properly construed as a law regulating insurance under a "common sense review of the issue" because nothing would prevent an ERISA plan from voluntarily adopting an identical external review provision itself. *See* Br. in Opp. at 7. According to respondent, "if a plan can voluntarily purchase insurance with an independent review provision, then a state, via the insurance regulation exception to ERISA preemption, can require it." *Id.* That theory can scarcely be used to uphold state *external* review statutes, whose distinguishing characteristic is that strangers to the plan—who are not fiduciaries and who frequently are shielded from any legal liability for their actions—make judgments about how plan assets must be spent that are *binding* on plan administrators.

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[12] The court of appeals concluded that Section 4-10 regulates insurance as a common-sense matter by adverting to a precedent holding that HMOs "'are insurance vehicles under Illinois law.'" *Moran*, 230 F.3d at 969 (quoting *Anderson v. Humana, Inc.*, 24 F.3d 889, 892 (7th Cir. 1994)). This Court has on occasion expressed reluctance to "disturb an appeals court's judgment * * * heavily dependent on analysis of state law." *Ward*, 526 U.S. at 368 (citing *Runyon v. McCrary*, 427 U.S. 160, 181-82 (1976)). That principle, however, applies only where the "District Court and Court of Appeals have concurred" on the state law's meaning (*Runyon*, 427 U.S. at 181; *see also Bishop v. Wood*, 426 U.S. 341, 346 (1976) (same)), which is not the case here. In any event, whether Section 4-10 is a law that "regulates insurance" under ERISA's saving clause is plainly governed by federal law. *See* 29 U.S.C. § 1144(b)(2)(A). The subsidiary judgments necessary to interpret that provision *also* present federal, not state, questions. *See SEC v. Variable Annuity Life Ins. Co. of Am.*, 359 U.S. 65, 69 (1959) ("the meaning of 'insurance' under * * * Federal Acts is a federal question"). Indeed, it is far from clear why a court of appeals' judgment on a matter of "common sense" is entitled to deference, particularly where, as here, that judgment does not depend on an *interpretation* of a state's law, but on an assessment of its *effect*.

Contrary to respondent's suggestion, there are substantial limits on the authority of a plan administrator to delegate final claims-processing authority to an outside party not bound by fiduciary duties. Any such delegation would likely violate the express terms of Section 503, which requires every employee benefit plan to "afford a reasonable opportunity to any participant whose claim for benefits has been denied a full and fair review *by the appropriate named fiduciary* of the decision denying the claim." 29 U.S.C. § 1133(2) (emphasis added). In addition, the delegation of claims processing to a party not bound by fiduciary duties is *itself* likely to constitute a breach of fiduciary duty by the plan administrator. Claims processing is a fiduciary function. *See* Susan P. Serota, ERISA FIDUCIARY LAW 152-53 (1995) (collecting cases). A plan administrator necessarily abdicates its statutorily-mandated fiduciary duty to review claims fully and fairly when it delegates final claims-processing authority to a nonfiduciary. Benefit determinations conducted pursuant to such a delegation are in all likelihood invalid, because "no discretion w[ill have been] exercised by the body given that authority under the terms of the Plan." *Nelson v. EG&G Energy Meas. Group, Inc.*, 37 F.3d 1384, 1388 (9th Cir. 1994).[13]

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[13] Although Moran also argued in the court of appeals that external review statutes might be upheld as a form of permissible "arbitration," *see* Br. of Plaintiff-Appellant Moran at 21-22, her argument ignores that Congress, by statute, has adopted a strong policy in favor of *voluntary* arbitration, and also specified the consequences of such an agreement, the available methods for enforcement, and the appropriate standards for judicial review. Under Congress' scheme, arbitration conducted pursuant to the Federal Arbitration Act, 9 U.S.C § 1 *et seq.*, is not an *alternative* enforcement mechanism to Section 502, but a federally-sanctioned *substitute* for it. *See Mitsubishi Motors Corp. v. Soler Chrysler-Plymouth, Inc.*, 473 U.S. 614, 628 (1985). Given that "[w]ithout the FAA's strong policy in favor of arbitration to tip the scales, an ERISA plaintiff might * * * show that an ERISA-governed plan's arbitration clause is unenforceable because it conflicts with statutory provisions or regulations governing the judicial review of benefits determinations under ERISA" (*Chappel v. Laboratory Corp. of Am.*, 232 F.3d 719, 725 n.4 (9th Cir. 2000)), it fol-

Indeed, even if delegation of claims-processing authority to a non-fiduciary *were* proper in some circumstances, the plan administrator would be required to monitor and supervise the delegatee's conduct, *see* 29 U.S.C. § 1105(c)(2)(A)(iii)—a duty that would be impossible to execute given that plan administrators have no discretion to review or set aside an external reviewer's benefits determination. Thus, respondent's claim that Section 4-10 is an insurance law because plan administrators can adopt external review on their own is premised on an erroneous assumption: ERISA's fiduciary requirements would prevent the plan administrator from abdicating his authority to a third party, not bound by fiduciary duties, whose decisions about how plan assets will be spent are binding on the administrator.[14]

3. Nor does Section 4-10 satisfy any of the three McCarran-Ferguson Act factors. Section 4-10 does not meet the first McCarran-Ferguson factor because external review does not transfer or spread a policyholder's risk. In *Union Labor*

[Footnote continued from previous page]

lows *a fortiori* that *state* independent review statutes, which lack *any* federal mandate, and which are imposed by operation of law on unwilling parties, cannot evade invalidation as alternative enforcement mechanisms to Section 502.

14 It is no response to suggest that this Court might solve the problem with respondent's theory by decreeing that the external reviewers will become subject to fiduciary duties by operation of law. Virtually all state independent review laws provide essentially blanket immunity to independent reviewers for claims arising out of their independent review services. *See, e.g.*, 215 IL COMP. STAT. 134/45(f)(6); 28 N.Y. INS. LAW § 4914(c); TEXAS INS. CODE Art. 21.58C § 2(g); VA. CODE ANN. § 38.2-5902(C). If this Court were to mandate that all independent reviewers be treated as plan fiduciaries, it also would be required to invalidate the provisions that immunize those presumed "fiduciaries" from civil liability, at least to the extent necessary to subject them to suit under ERISA's remedial scheme. It hardly needs stating that this Court should not invalidate one state law to save another, especially where neither law might have passed if the state legislature had labored under a correct apprehension of federal requirements.

Life Ins. Co. v. Pireno, 458 U.S. 119 (1982), this Court held that a peer review committee's examination of whether medical care provided to an insured is reasonably charged and medically necessary does not "spread[] and underwrit[e] * * * a policyholder's risk." *Id.* at 130. As this Court recognized, risk is allocated when the insurance contract is executed, not when particular claims are adjusted. *Id.* Like the external review mechanism at issue in *Pireno*, the independent review authorized by Section 4-10 is "logically and temporally unconnected to the transfer of risk accomplished by" its subscriber contracts, even if those contracts otherwise could be viewed as "insurance." *Id.* The first McCarran-Ferguson factor therefore is not satisfied.[15]

Nor is Section 4-10 an "integral part of the policy relationship between insurer and insured" (*Pireno*, 458 U.S. at 131)—the second factor. External claims review procedures do not "so closely affect[] the reliability, interpretation, and enforcement of the insurance contract * * * as to fall within the [business of insurance]," because external review "is a separate arrangement * * * [with] third parties not engaged in the business of insurance," even if, as was true in *Pireno*, the insurer uses the peer review system "as an aid in its [claims] decisionmaking." *Id.* at 130-32. As this Court recognized in *Department of Treasury v. Fabe*, 508 U.S. 491, 503 (1993), such mechanisms have "nothing to do with whether the insurance contract [is] performed; [they] deal only with calculating what f[alls] within the scope of the contract's coverage"—*i.e.*, precisely what federal courts are

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15 The court of appeals did not address whether Section 4-10 spreads or transfers a subscriber's risk, even though that factor constitutes the "one 'indispensable characteristic of insurance.'" *Pireno*, 458 U.S. at 130 (quoting *Royal Drug*, 440 U.S. at 212); *see also Variable Annuity Life Ins. Co.*, 359 U.S. at 71 ("the concept of 'insurance' involves some investment risk-taking on the part of the company"). The Fifth Circuit in *Montemayor* recognized that Texas' independent review provisions "probably do not * * * reallocat[e] the risk between the insured and insurer." 215 F.3d at 538.

called upon to decide under ERISA § 502(a). The second McCarran-Ferguson factor therefore is not satisfied.

Finally, Section 4-10 is *not* aimed directly at the insurance industry. The statute applies to HMOs, including those that perform purely administrative functions for self-funded plans. Because on its face Section 4-10 is not "limited to entities within the insurance industry" and is not "a law governing the insurance relationship distinctively" (*Ward*, 526 U.S. at 375), the third McCarran-Ferguson factor is not satisfied.

D. Summary Judgment For Respondent Was Improper.

Thus, the court of appeals erred in granting summary judgment to Moran. Section 4-10 constitutes an alternative enforcement mechanism to Section 502 and in any event does not "regulate insurance" from a common-sense view of the matter or satisfy any of the three McCarran-Ferguson factors. Accordingly, it is preempted by Section 502(a) and 514(a) and is not saved from preemption under the saving clause. Rush therefore was not obliged to comply with the independent reviewer's determination that Dr. Terzis' surgery was "medically necessary," and its rejection of Moran's benefits claim was not otherwise an abuse of discretion. *See Firestone Tire & Rubber Co.*, 489 U.S. at 107.

CONCLUSION

For the foregoing reasons, the judgment of the court of appeals should be reversed.

Respectfully submitted.

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RUSH PRUDENTIAL HMO, INC.,
Petitioner,

v.

DEBRA C. MORAN AND STATE OF ILLINOIS,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

BRIEF OF THE AMERICAN MEDICAL ASSOCIATION, THE ILLINOIS STATE MEDICAL SOCIETY, AND THE AMERICAN PSYCHIATRIC ASSOCIATION, AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS

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INTEREST OF *AMICI CURIAE*

The American Medical Association ("AMA") and the Illinois State Medical Society ("ISMS"), Illinois not-for-profit corporations, and the American Psychiatric Association ("APA") submit this brief *amicus curiae* in support of respondents Debra C. Moran and the State of Illinois.[1] Founded in 1847, the AMA is the largest medical society in the United States. Its approximately 275,000 physicians practice in all fields of medical specialization and in every state. The AMA is dedicated to promoting the science and art of medicine and the betterment of public health.

ISMS is an association of more than 11,000 physicians who reside or practice in the State of Illinois. It was founded in 1840 to promote the science and art of medicine, protect public health, elevate the standards of medical education, and unite the medical profession in Illinois.

The APA, with approximately 42,000 members, is the Nation's leading organization of physicians specializing in psychiatry. The APA has participated in numerous cases in this Court. The APA and its members have a strong interest in ensuring that HMO financial incentives do not impair patients' ability to receive proper medical care.

The members of the AMA, ISMS, and APA seek to protect the integrity of the patient-physician relationship in order to

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[1] Counsel for the AMA, the ISMS, and the APA authored this brief in its entirety. The AMA/State Medical Society Litigation Center ("Litigation Center") is a coalition of the AMA and private, voluntary, non-profit state medical societies established to present the views of the medical profession to the courts. The Litigation Center, representing the AMA and the 50 state medical societies which are its members, and the APA paid for this brief. No monetary contributions to the preparation or submission of this brief were received from any other source. Sup. Ct. R. 37.6. The parties have consented to the filing of this brief, and the consent letters have been filed with the Clerk of the Court. *Id.* 37.3.

provide quality medical care for patients. Their activities promote a health-care system in which all Americans have access to affordable medical care *and* in which treatment decisions are made by knowledgeable physicians who practice subject to traditional state regulation and the ethical values of the profession. In furtherance of these goals, the AMA has adopted the Principles of Medical Ethics, a set of "standards of conduct which define the essentials of honorable behavior for the physician." AMA, *Code of Medical Ethics* (2001), *available at* http://www.ama-assn.org/ama/upload/mm/ 369/2001_principles.pdf. Under these principles, physicians are obligated to "regard responsibility to the patient as paramount" and "to seek change to those [legal] requirements which are contrary to the best interests of the patient." *Id.* (Principles VIII, III). In addition, the AMA has sought to protect state jurisdiction over regulation of the quality of medical care and medical-necessity determinations from preemption by federal law. See AMA, H-165.875, *Establishment of Liability of Managed Care Organizations, in Policies of the AMA House of Delegates* ("*AMA Policy*") (1999), *available at* http://www.ama-assn.org/apps/pf_online (endorsing federal legislation to amend ERISA expressly to provide that state regulation of quality of medical care and medical-necessity determinations are not preempted).[2]

This case poses the question whether independent-review laws enacted by states are preempted by ERISA. Such laws require managed-care organizations to allow a neutral physician to review and resolve disputes between physicians, patients, and managed-care organizations about the medical

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[2] The health policies of the AMA are established by the House of Delegates. These policies "are based on professional principles and scientific standards" and "represent the consensus viewpoints of many thousands of physicians gained through years of professional practice." AMA, *PolicyFinder: About AMA Policy* (1995-1998), *available at* http://www.ama-assn.org/apps/pf_online.

necessity of treatment. These laws help ensure that patients enrolled in managed-care organizations receive medically-necessary health care. *Amici* have concluded, based on substantial academic research and commentary and significant practical experience, that independent-review laws, such as the statute upheld by the Seventh Circuit in this case, protect the integrity of the patient-physician relationship in the managed-care context and serve the best interest of patients. See AMA, H-285.931, *The Critical Role of Physicians in Health Plans and Integrated Delivery Systems, in AMA Policy* (adopting policy that patients' health plans and integrated health-care delivery systems should "be able to appeal the medical necessity determination or coverage decision to an independent review organization"); *id.* H-285.998, *Managed Care, in AMA Policy* ¶ 5 (same); *id.* H-320.952, *External Grievance Review Procedures, in AMA Policy* ¶ 3 (same); *id.* H-320.953, *Definitions of "Screening" and "Medical Necessity", in AMA Policy* ("[u]sage of the term 'medical necessity' must be consistent between the medical profession and the insurance industry").

The need for independent-review laws arises when the functions of insurer and health-care provider are merged, as they are in managed care. In these circumstances, a significant risk arises that medical-treatment decisions will be made, not by the patient's physician, but by a managed-care administrator who will subordinate proper patient care to cost considerations. As a practical matter, an HMO's decision to deny coverage for a prescribed medical treatment often results in the patient being unable to afford, and thus having to forgo, necessary treatment. Independent-review laws diminish such risks. They do so by regulating insurance and health care, two areas which lie at the heart of traditional state regulation and which presumptively are not preempted by federal law.

For these reasons, the AMA and other medical societies have promoted independent-review laws before state legislatures, the United States Congress, and courts

throughout the country. In addition, the AMA, as *amicus curiae* in the court below and in other cases addressing independent-review laws, has sought to defend such laws from assertions of preemption.

Here, the Seventh Circuit correctly held that the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1001, *et seq.*) ("ERISA"), did not preempt Illinois' independent review law, 215 Ill. Comp. Stat. § 125/4-10(a) ("section 4-10(a)"). *Moran* v. *Rush Prudential HMO, Inc.*, 230 F.3d 959, 972 (7th Cir. 2000), *cert. granted*, 121 S. Ct. 2589 (2001). The Seventh Circuit concluded that section 4-10(a) permissibly regulates insurance and health care in the State of Illinois and does not impinge upon ERISA's remedial scheme. The *Moran* decision allows the state to protect insureds and patients and to preserve the patient-physician relationship by authorizing external, independent review in a non-judicial forum of disputes between insurers and a patient's primary care physician about proper medical treatment. In contrast, the Fifth Circuit has concluded that this traditional state regulation is preempted by ERISA, leaving a significant gap in the regulation of managed-care organizations and thus in the protection of insureds and patients. See *Corporate Health Ins., Inc.* v. *Texas Dep't of Ins.*, 215 F.3d 526, 538-39 (5th Cir. 2000). The resolution of this conflict is likely to determine the legal viability of all state independent-review laws.

Amici have a strong interest in the proper resolution of this case.

SUMMARY OF ARGUMENT

The issue in this case is whether Illinois and other states can enact laws requiring independent review of the medical-necessity determinations of HMOs acting as insurers or whether such laws are preempted by ERISA. The court of appeals in this case correctly concluded that Illinois' law

regulates insurance and health care and does not conflict with ERISA's civil enforcement scheme. The court therefore held that the law is not preempted by ERISA. *Amici* file this brief to demonstrate both that the decision below is correct and that state regulation of HMOs acting as insurers is consistent with ERISA's explicit preservation of state authority in this area and with its overall goal of protecting ERISA plan participants and beneficiaries.

An analysis of the preemption question at issue begins with the fundamental premise that Congress did not intend to preempt state regulation of insurance. Indeed, Congress included a savings clause that expressly preserves the states' authority to regulate insurers, even when that regulation "relates to" an ERISA plan. See 29 U.S.C. § 1144(b)(2). Equally critically, the court must presume that Congress did not intend to preempt Illinois' exercise of its power to regulate health care. See, *e.g.*, *Hillsborough County* v. *Automated Med. Labs., Inc.*, 471 U.S. 707, 719 (1985).

Section 4-10(a) is a regulation of both insurance and health care and thus wholly saved from ERISA preemption, as is demonstrated by application of the framework found in *UNUM Life Insurance Co. of America* v. *Ward*, 526 U.S. 358, 367, 374 (1999). First, despite petitioner's and its *amici*'s protests to the contrary, section 4-10(a) applies only to HMOs acting as insurers, reinsurers, or agents for insurers performing an insurance function and thus regulates insurance from "'a common-sense view of the matter.'" *Id.* at 367 (quoting *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724, 740 (1985)). Practically speaking, the independent-review law regulates only HMOs in a position to deny payment or coverage for a medical treatment that the insured patient's primary care physician deems medically necessary, *i.e.*, only HMOs acting as insurers. See *infra* 15-16. Moreover, whenever the HMO is providing or arranging for health care that spreads risk, it is legally obligated to provide the care and acting as a reinsurer. Indeed, an HMO that

arranges insured care and processes claims under such an arrangement is necessarily the agent of the insurer; it is performing the claims processing function, a core insurance function. Finally, the policy concerns underlying Section 4-10(a) are directed at HMOs acting as insurers.

This common sense perspective is confirmed by application of the McCarran-Ferguson guideposts. Section 4-10(a) serves as "an integral part of the policy relationship between the insurer and the insured," *Metropolitan Life Insurance Co.* v. *Massachusetts*, 471 U.S. 724, 743 (1985); "is limited to entities within the insurance industry," *UNUM Life*, 526 U.S. at 375; and spreads risk among policy holders, *id.* None of these factors is determinative but their application, aided by common sense, shows that section 4-10(a) is directed at the insurance business.

This Court's decision in *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41 (1987) is the sole basis of the argument that independent-review laws are preempted, but there is no conflict between respondent's action filed under ERISA section 502(a) and ERISA's civil enforcement scheme. In *Pilot Life*, the ERISA plan beneficiary filed a state cause of action that was not saved from preemption by the insurance savings clause. In addition, he sought punitive damages for the denial of benefits from an ERISA plan although such damages are not permitted under ERISA's enforcement scheme. Here, respondent's claim is brought under section 502(a) of ERISA, invokes a law saved from preemption by the insurance savings clause as the rule of decision in her ERISA action, and seeks only the relief authorized by ERISA's civil enforcement scheme. *Pilot Life* should not be extended to these wholly different circumstances.

Section 502(a) of ERISA is the exclusive cause of action for ERISA benefits and was modeled on section 301(a) of the Labor Management Relations Act, the exclusive cause of action for enforcement of collective bargaining agreements. But independent-review laws, which define medical

necessity, are analogous to labor arbitration agreements, which define the meaning of collective bargaining agreements. No one contends or believes that the labor arbitration of the meaning of a collective agreement somehow impinges upon the exclusivity of section 301(a) in enforcing such agreements; similarly, the arbitration of medical-necessity decisions does not impinge upon the exclusivity of ERISA section 502(a).

Finally, the independent-review laws passed in Illinois and other states further ERISA's goal of complementary state and federal regulation protecting the rights of ERISA plan beneficiaries and participants. Exercising the police power to protect public health, the states have enacted independent-review laws to ensure that citizens whose health care is insured by HMOs receive medically-necessary treatment. The laws serve that important goal in critical ways. They require medical-necessity decisions to be made by physicians, protecting the health of the patient and the integrity of the patient-physician relationship. Independent review also gives patients an assurance that their interests are being fairly considered—even where the ultimate decision is that the insurer will not pay for the requested treatment. This, in turn, improves the public perception of the health-care system and may prevent substantial litigation. States are at the vanguard of the movement to protect patients through regulation like independent review; and, currently, their participation in the system is critical to ensuring that insured patients' health-care interests are guarded.

For all of these reasons, *amici* urge this Court to affirm the Seventh Circuit's decision, allowing states to continue their efforts to protect their citizens' health by regulating HMOs acting as insurers.

ARGUMENT

I. ERISA PRESERVES STATE REGULATION OF INSURANCE AND HEALTH CARE AND THUS STATE LAWS DIRECTED AT HMOS AS INSURERS.

Traditionally, health care in the United States was provided on a fee-for-service basis. Physicians and other health-care providers delivered care. They were separate from insurers, the entities responsible for paying for the treatment. In the late 1960s and early 1970s, increases in health-care costs led to the development of alternative forms of health-care delivery and financing, including HMOs and other managed-care organizations. These organizations assume some or all of the financial risk of providing health care. Put differently, in these organizations, in contrast to fee-for-service health care, the roles of health-care provider and insurer are merged. See generally *Pegram* v. *Herdrich*, 530 U.S. 211, 218-19 (2000).

This case, like other cases involving managed care, exists at the confluence of two powerful, traditional state interests – *viz.*, the state interests in the regulation of health care and of insurance. Section 4-10(a) of the Illinois Code requires HMOs to provide independent external review and determination of any dispute between an HMO and a patient's primary care physician "regarding the medical necessity of a covered service proposed by a primary care physician." 215 Ill. Comp. Stat. § 125/4-10(a). This law regulates health care and the insurance industry because the HMOs to which it applies are both health-care providers and insurers.[3]

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[3] *See* 42 U.S.C. § 300e(c) ("[e]ach HMO shall . . . assume full financial risk on a prospective basis for the provision of basic health services, except that a[n] [HMO] may make arrangements with physicians or other health professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians or other health professionals or through the institutions"); 215 Ill. Comp. Stat. § 125/1-2(9) (defining an HMO as "any organization formed . . . to provide or arrange for one or more health care plans under a system which causes any part of the risk of health care delivery to be borne by the organization or its providers").

This Court has recently instructed that the scope of ERISA preemption must be determined against a background "assumption that the historic police powers of the States were not be superseded by the Federal Act unless that was the clear and manifest purpose of Congress." *New York Conference of Blue Cross & Blue Shield Plans* v. *Travelers Insurance Co.*, 514 U.S. 645, 655 (1995); see also *DeBuono* v. *NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 813 n.8 (1997). Pertinent here, there exists a strong presumption against ERISA preemption of state regulation of health care. "[N]othing in the language of [ERISA] or in the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *Travelers*, 514 U.S. at 661 (citing *Hillsborough County*, 471 U.S. at 719). See also *Pegram*, 530 U.S. at 237; *DeBuono*, 520 U.S. at 815-16. And, ERISA itself expressly preserves state regulation of the business of insurance in section 514(b), 29 U.S.C. § 1144(b)(2). See also *UNUM Life*, 526 U.S. 373-75.

The nature of the regulation at issue thus militates strongly against a finding of ERISA preemption. That point is underlined by consideration of the implications of preemption in this context. ERISA does not substantively regulate HMOs' medical-treatment decisions. See, *e.g.*, *Travelers*, 514 U.S. at 651 (ERISA "does not go about protecting plan participants and their beneficiaries by requiring employers to provide any given set of minimum benefits"). Accordingly, to the extent state regulation is displaced, HMOs are not subject to any corresponding federal regulation. Ironically,

ERISA participants and beneficiaries – the object of Congressional solicitude in ERISA – will be deprived of protection.

Like the subject matter and the policy interests at stake here, a rigorous analysis of the statute and this Court's cases leads inexorably to the conclusion that section 4-10(a) is not preempted.

II. ILLINOIS' INDEPENDENT-REVIEW LAW IS DIRECTED TOWARD HMOS AS INSURERS AND DOES NOT CONFLICT WITH ERISA'S CIVIL ENFORCEMENT SCHEME.

Respondent Moran's action is a claim for benefits from an employee welfare plan under ERISA's civil enforcement provision, section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B). Respondent contends that she is entitled to reimbursement for the cost of her microneurolysis surgery. Specifically, she asserts that under section 4-10(a), the Illinois statute providing for independent review of disputes between HMOs and primary care physicians, the independent reviewer determined that her surgery was medically necessary; that this determination was binding on the HMO; and that the independent-review process was not preempted by ERISA. The petitioner HMO asserts, however, that it determined that Moran was not entitled to this benefit and that section 4-10(a) is preempted.

Section 514(a) of ERISA preempts any state law to the extent that the law "relate[s] to any employee benefit plan." Although *amici* do not focus on this point, they agree with respondents that section 4-10(a) does not "relate[] to" an ERISA plan, as this Court has most recently developed that test. Illinois' independent-review law is a general health-care regulation, an area which historically has been a matter of local concern. *Travelers*, 514 U.S. at 661. The act neither "refer[s] to" nor "has a connection with" employee benefit plans, *id.*; rather, it regulates disputes between HMOs and

patients concerning the treatment decisions of physicians at HMOs. The law may indirectly burden ERISA plans, because some plans provide benefits through HMOs, and HMOs must now arbitrate disputes concerning physicians' treatment decisions. But *Travelers* teaches that this indirect effect is insufficient to require preemption under ERISA section 514(a), 29 U.S.C. § 1144(a). And *Pegram* provides support for this determination by holding that physicians' treatment and mixed eligibility/treatment decisions are not fiduciary decisions under ERISA. 530 U.S. at 231. The relates-to test has evolved, and its current manifestation acknowledges the states' strong interest in maintaining regulatory authority in traditional realms such as health care.

Even assuming, however, that section 4-10(a) "relate[s] to" ERISA plans, it is saved from preemption by subsection 514(b)(2)(A) of ERISA. That subsection saves state laws from preemption when those laws "regulate[] insurance." 29 U.S.C. § 1144(b)(2)(A).[4] The questions for decision are (i) whether the Illinois law is saved from preemption by ERISA subsection 514(b)(2)(A) as a "law of any State which regulates insurance"; and (ii) whether, even assuming that section 4-10(a) is a law regulating insurance, the law is nonetheless preempted because it creates a state law remedy that conflicts with ERISA's civil enforcement scheme. *Pilot Life*, 481 U.S. at 55.

Amici first show that section 4-10(a) regulates insurance. We then demonstrate that petitioner's argument that section

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[4] Another clause in section 514 creates an exception to the savings clause exception known as the deemer clause, section 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B). This clause "makes clear that a state law that 'purport[s] to regulate insurance' cannot deem an employee benefit plan to be an insurance company." *Pilot Life*, 481 U.S. at 45. The deemer clause simply exempts self-funded ERISA plans from state laws that regulate insurance under the saving clause. Because the plan at issue is insured, not self-funded, the deemer clause does not apply. *FMC Corp.* v. *Holliday*, 498 U.S. 52, 61 (1990).

4-10(a) is preempted rests on a substantial overreading of *Pilot Life*, a decision finding ERISA preemption of a state common law cause of action that (i) was not preserved by the insurance savings clause and (ii) authorized punitive damages not permitted under ERISA's enforcement scheme. In contrast, there is no conflict with ERISA when a plan participant or beneficiary uses the Illinois independent-review law as a rule of decision in an enforcement action brought under section 502(a) of ERISA and seeking only relief authorized under ERISA's civil enforcement scheme.

A. Section 4-10(a) Is Directed At The Business Of Insurance.

This Court's "precedent provides a framework for resolving whether a state law 'regulates insurance' within the meaning of the saving clause." *UNUM Life*, 526 U.S. at 367. First, a court inquires whether "from a 'common sense view of the matter,' the contested prescription regulates insurance." *Id.* (quoting *Metropolitan Life*, 471 U.S. at 740). Then, the court considers the three McCarran-Ferguson Act factors as "guideposts, not separate essential elements" in assessing whether the regulation fits within the "business of insurance." *Id.* at 374.

Illinois' independent-review law is "directed toward" the business of insurance and thus "'regulates insurance'" in a common-sense understanding of the term. *Pilot Life*, 481 U.S. at 50. First, HMOs "are insurance vehicles under Illinois law." *Anderson* v. *Humana, Inc.*, 24 F.3d 889, 892 (7th Cir. 1994). The Seventh Circuit has so concluded in this case and others. This Court does "not normally disturb an appeals court's judgment on an issue so heavily dependent on analysis of state law." *UNUM Life*, 526 U.S. at 368 (citing *Runyon* v. *McCrary*, 427 U.S. 160, 181-82 (1976)). Petitioner and its *amici* have given the Court no reason to depart from its usual practice of deference to the appeals court's determination of state law.

Second, and equally to the point, HMOs evolved precisely in order that health-care providers would also bear risk and thus have an incentive to control costs. See *Group Life & Health Ins. Co.* v. *Royal Drug Co.*, 440 U.S. 205, 227 n.34 (1979) ("certain aspects" of advance payment medical benefits plans may be the "business of insurance"); *Washington Physicians Serv. Ass'n* v. *Gregoire*, 147 F.3d 1039, 1045-46 (9th Cir. 1998), *cert. denied*, 525 U.S. 1141 (1999). Illinois, like other states, enacted its independent-review law in direct response to the merger of the roles of health-care provider and insurer in HMOs and the resulting danger that medical-treatment decisions will be unduly infected by cost considerations. Other courts of appeals, like the Seventh Circuit, have generally concluded that HMOs are insurers. See *Express Scripts, Inc.* v. *Wenzel*, 262 F.3d 829, 835 (8th Cir. 2001) ("HMOs both spread and underwrite risk, and we agree with other circuit courts which have concluded that HMOs are insurers") (citing *Kentucky Ass'n of Health Plans, Inc.* v. *Nichols*, 227 F.3d 352, 364-65 (6th Cir. 2000), *Corporate Health Ins., Inc.*, 215 F.3d at 538, *Gregoire*, 147 F.3d at 1045-46). But see *O'Reilly* v. *Ceuleers*, 912 F.2d 1383, 1389 (11th Cir. 1990). Independent-review laws simply assure that HMOs bear the risk they have assumed, confirming that these laws regulate insurance for ERISA purposes.

Petitioner and its *amici* base their contention that section 4-10(a) is not directed at the insurance business and thus does not regulate insurance in the common-sense understanding of the term on the premise that the law may apply to some HMOs that are not acting as insurers. By definition, under the Illinois law, HMOs are entities that "provide or arrange" for health care in a way which spreads risk to the HMO or the providers that have contracted with the HMO. See 215 Ill. Comp. Stat. § 125/1-2(9). As we now show, the application of section 4-10(a) is limited to situations in which HMOs are acting as insurers.

Many HMOs provide or arrange health care and bear some or all of the resulting risk and thus combine the health-care provision and insurer functions. See Jonathan P. Weiner & Gregory de Lissovoy, *Razing A Tower of Babel: A Taxonomy for Managed Care and Health Insurance Plans*, 18 J. Health Pol., Pol'y & L. 75, 85, 87, 96 (1993). A law directed at HMOs which have both characteristics plainly is directed at the insurance business. Petitioner does not appear to dispute that section 4-10(a) regulates the business of insurance to the extent it is directed at HMOs that both provide health care and bear risk. Even under petitioner's theory, then, an independent-review law that so defined HMOs would not be preempted.

Some HMOs may provide or arrange health care by entering into agreements with medical providers which themselves bear *all* of the risk of medical costs higher than the insured's payments. This situation is not the norm. See *id.* at 96 (defining HMO as "a prepaid organized delivery system where the organization *and* the primary care physicians assume some financial risk for the care provided to its enrolled members"); *id.* at 86-87 ("risk may or may not be shared significantly by an intermediary, except, as noted, in the case of the two classes of HMOs, where the plan always bears the majority of risk"). But, leaving this practical point aside, petitioner and its *amici* argue that an HMO that provides or arranges care, but bears no risk, would meet the definition of an HMO under Illinois law but is not an insurer. Thus, the argument goes, section 4-10(a) is not directed at the business of insurance. This is wrong, as consideration of the actual application of section 4-10(a) illustrates.

An HMO cannot forbid a physician to provide or an insured to receive a medical treatment; it can only refuse to pay. Thus, it is when a primary care physician concludes that a particular medical treatment is authorized and the HMO refuses to *pay for* the treatment that the insured patient may seek independent review of the HMO's decision under section

4-10(a). If the physician and other health-care providers have themselves taken on all of the risk of the cost of health care, the physician's decision to provide a particular treatment does not impose a cost on the HMO, and it cannot constructively veto the treatment ordered by the physician by withholding payment.

As a practical matter, what this means is that the independent review law applies when an HMO has refused to pay, *i.e.*, when the HMO is acting as an *insurer*. See E.H. Morreim, *Confusion in the Courts: Managed Care Financial Structures and Their Impact on Medical Care*, 35 Tort & Ins. L.J. 699, 707 (2000) ("[i]n a mature capitation arrangement [*i.e.*, where providers bear all risk], the HMO has no need to dictate clinical decisions about which patients should receive what care because those decisions no longer pose a financial risk").[5] As a legal matter, what this means is that section 4-10(a) is "specifically directed toward" the business of insurance. *Pilot Life*, 481 U.S. at 50. Accordingly, even if there is a theoretical possibility or a *de minimis* number of instances in which section 4-10(a) might apply to HMOs not

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[5] Indeed, it is difficult to see how an HMO which has transferred all risk to health-care providers could prevent a patient from receiving medical treatment and thus end up in an independent-review proceeding. Assume that the HMO engages in utilization review and concludes that a treatment is not medically necessary. That decision is not binding on the physician or physician group, and the physician or physician group to whom the HMO has transferred financial risk may simply provide the treatment. *See* Morreim, *supra* at 709 & n.44 (quoting 99 Op. Ohio Att'y Gen. 44 (1999) ("[a] physician or other provider retains authority to provide whatever services are deemed appropriate for the patient, even if the services are not included under the plan of the health insuring corporation")). Utilization review "is merely deciding whether or not third-party payment is available," *id.* at 709 n.44 (quoting 60 Op. N.C. Att'y Gen. 100 (1992)). If the health-care provider has assumed all financial risk, the HMO cannot prevent treatment by withholding payment, and independent review of the physician's decision would have no consequence.

directly acting as insurers, the law regulates insurance in any common-sense understanding of the term.

Equally critically, an HMO that provides or arranges health care through a network of physicians which bears *all* risk acts as an insurer for additional reasons. First, the HMO is a reinsurer in this context. As explained in an article cited by petitioner, an HMO which provides or arranges for care "is legally committed to provide care" for its enrolled members. Weiner & de Lissovoy, *supra* at 96; *id.* at 85 ("[i]n many managed care plans, the intermediary is legally committed to provide care, or to arrange for its provision, via a network of providers with which it has prenegotiated contracts"). The insured has a contract for medical care *with the HMO* at a specified monthly or annual fee, and it is the HMO that is ultimately responsible – *viz.*, the insurer – with respect to the provision of covered care.

Second, the HMO that arranges care from providers bearing all risk is processing claims for patients to whom it is contractually obligated to provide care. Claims processing is an archetypal insurer function. See Keeton & Widiss, *Insurance Law* § 6.9(a) (1988) ("Regulation of Claims Process"); *Union Labor Life Ins. Co.* v. *Pireno*, 458 U.S. 119, 136 & n.2 (1982) (Rehnquist, C.J., dissenting) (explaining that the "process of claims adjustment – the determination of the actual payments to be made to the insured for losses covered by the insurance contract" – is central to the contract between the insurer and the insured and thus the "essence of the 'business of insurance'"). The HMO which simply provides or arranges care by contracting with insurers is the agent of those insurers. An HMO may not avoid legal characterization as an insurer by itself performing only one insurance function and contracting out the rest.[6]

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[6] Petitioner and its *amici* suggest that some HMOs do not contract with employers, employer groups, or patients to provide insurance and simply administer claims for health-care providers. Such HMOs may fall outside of the Illinois act's definition of HMOs for they do not "provide or arrange for . . . [a] health care plan[]." 215 Ill. Comp. Stat. § 125/1-2(9). In that circumstance, too, however, the HMO is a claims processor and agent for the insurer health-care providers. If such HMOs are covered, they are acting as and on behalf of insurers and performing a core insurer function.

Finally, Illinois' regulation of HMOs "is grounded in policy concerns specific to the insurance industry," when its business merges with the business of health care. *UNUM Life*, 526 U.S. at 372. Specifically, Illinois, like many states and *amici*, is concerned about the ability of health-care providers, especially physicians, to make judgments about necessary medical treatment without undue emphasis on cost considerations when the insurance and health-care provider functions are combined. Section 4-10(a) is directed at this specific problem. Indeed, insofar as any policy concern not specific to the insurance industry is implicated by section 4-10(a), it is the State's legitimate and appropriate policy concern with health-care regulation. Common sense dictates that the Illinois law falls within the insurance savings clause and thus is saved from ERISA preemption. Cf. *Corporate Health Ins.*, 215 F.3d at 538 ("the independent review provisions are aimed at insuring entities and regulate the insured-insurer relationship, [so] they meet the common sense test of the saving clause").

The McCarran-Ferguson factors, which this Court describes as "guideposts" or "considerations to be weighed" in determining whether a law regulates insurance, also strongly support application of the insurance savings clause here. *UNUM Life*, 526 U.S. at 373-74. Those factors are whether the law "has the effect of transferring or spreading a policyholder's risk," *Metropolitan Life*, 471 U.S. at 743; whether it serves as "an integral part of the policy relationship between the insurer and the insured," *id.* at 743; and "whether the rule is limited to entities within the insurance industry," *UNUM Life*, 526 U.S. at 375.

As both the Seventh and Fifth Circuits have concluded, independent-review laws like section 4-10(a) easily satisfy the second and third McCarran-Ferguson factors. Such laws are integral to the policy relationship, because they "change the bargain between insurer and insured." *Id.* at 374. See also *id.* at 375 (the law "dictates the terms of the relationship between the insurer and the insured, and consequently, is integral to that relationship") (internal quotations and citation omitted). Moreover, for reasons set forth above, they also directly regulate the insurance industry. See *id.* (the law "focuses on the insurance industry"); *id.* (the rule "'does not merely have an impact on the insurance industry; it is aimed at it'") (quoting *FMC Corp.*, 498 U.S. at 61)). Because the common-sense view of the law is "verif[ied]" by two of the remaining three McCarran-Ferguson factors, an analysis of the first factor "need not [be] pursue[d]." *Id.* at 374. If this Court were to address whether section 4-10(a) spreads risk, *amici* submit that the law transfers a policy holder's risk. Specifically, it shifts the risk of erroneous medical-necessity determinations from the insured patient to the HMO, potentially raising premiums and spreading risk among all insurance policy holders. See *Metropolitan Life*, 471 U.S. at 742 (holding that a state law adding a benefit to an insurance contract required the parties to spread an additional risk to all policyholders).

The insurance savings clause applies here. That leaves for decision the question whether section 4-10(a) is "nonetheless preempted because it conflicts with substantive provisions of ERISA." *Pilot Life*, 481 U.S. at 357. To that question we now turn.

B. Moran's Action Does Not Conflict With ERISA Section 502(a).

Section 4-10(a) does not conflict with any provision of ERISA and specifically does not conflict with its civil enforcement scheme. Although respondent Moran initially filed a state law action to enforce section 4-10(a), her lawsuit

was removed to federal court. The district court determined that her state law action was a suit "to recover benefits due . . . under the terms of [a] plan," 29 U.S.C. § 1132(a)(1)(B), and thus preempted. The Seventh Circuit affirmed this decision, and respondent did not cross-petition. Accordingly, the case before this Court is a suit to recover benefits brought under section 502(a)(1)(B) of ERISA's civil enforcement scheme. Put differently, this action does not conflict with ERISA's exclusive civil enforcement scheme; it utilizes it.[7]

The most apposite precedent of this Court is *UNUM Life*. There the insurer argued that a state rule conflicted with ERISA's enforcement scheme. This Court, however, simply pointed out that the insured had "sued under § 502(a)(1)(B) 'to recover benefits due . . . under the terms of his plan.' The [state law] rule supplied the relevant rule of decision for this §502(a) suit." 526 U.S. at 377. Similarly here, section 4-10(a) simply supplied the relevant "rule of decision" for the insured's section 502(a) suit – *viz.*, it determined through an independent-review process akin to arbitration whether the insured's primary physician correctly determined that she should have microneurolysis surgery.[8] See also *Metropolitan*

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[7] For that reason, in this case, as in *UNUM Life*, the Court need not decide whether a state insurance law that creates an alternative state-law remedy comes within the savings clause and is saved from preemption or whether it nonetheless conflicts with ERISA's exclusive enforcement scheme and is preempted under *Pilot Life*. Here the claim before the Court is an ERISA section 502(a) claim, and the state law merely provides the "relevant rule of decision in [that] §502(a) action." 526 U.S. at 376-77 & n.6.

[8] The Illinois act mandates external review not internal review. Neither ERISA nor its implementing regulations purport to limit external review of medical-necessity determinations. In contrast, ERISA does address internal review procedures; even there, however, ERISA defines only a floor that such processes must achieve rather than occupying the field. *See* 29 U.S.C. § 1133 (requiring plans to provide notice and the opportunity for review of denied claims); 29 C.F.R. pt. 2560 (setting forth

Life, 471 U.S. at 744 (holding that a state law mandating the provision of certain insurance benefits was saved from preemption by the savings clause); *FMC Corp.*, 498 U.S. 60 (holding that a state anti-subrogation rule was saved from preemption although the law affected the plan's payment of benefits).

The state laws at issue here, in *Metropolitan Life*, and in *FMC Corp.* are all, as a matter of state insurance law, incorporated into the terms of the insurance purchased by plans in the pertinent states. Each is simply part of the terms and conditions an insurer accepts as part of the cost of doing business in the state in question,[9] and none thereby conflicts with any substantive provision of ERISA, including its civil enforcement scheme.[10] Quite to the contrary, Moran's insurance policy provided that Rush Prudential would pay for her medically-necessary health care. ERISA section 502(a) specifies that Moran, as a plan beneficiary, is entitled to such

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the minimum requirements for benefit claims procedures for employee benefit plans). *See also UNUM Life*, 526 U.S. at 377 (holding that "[b]y allowing a longer period to file than the *minimum* filing terms mandated by federal law, the [state law] rule complements rather than contradicts ERISA and the regulations").

[9] That incorporation is not simply implicit here. This plan, as the Court of Appeals expressly noted, expressly incorporates state law conditions.

[10] The Department of Labor's claim processing regulations specifically express the Department's belief that the regulations do not preempt state insurance laws authorizing independent review. The regulations specify that they preempt state laws regulating insurance only "to the extent that such law prevents the application of a requirement" of the claims processing regulations and further that for this purpose, "a State law regulating insurance shall not be considered to prevent the application" of the claims processing regulations "merely because such State law establishes a review procedure to evaluate and resolve disputes involving adverse benefit determinations under group health plans so long as the review procedure is conducted by a person or entity other than the insurer, the plan, plan fiduciaries, the employer, or any employee or agent of the foregoing." 29 C.F.R. 2560.503-1(k)(1) & (2)(i).

payment. Thus, section 4-10(a) furthers, rather than frustrates, congressional intent.

Pilot Life is not to the contrary. In that case, this Court considered whether Mississippi common law creating a state cause of action for bad-faith breach of contract conflicted with ERISA's civil enforcement scheme. The Court held that the state law cause of action "relate[d] to" an ERISA plan and rejected the argument that the insurance savings clause applied. That analysis would have decided the case; but, in reaching the conclusion that the state cause of action was preempted, this Court went on to characterize ERISA's civil enforcement provisions as the exclusive remedy for benefits under an ERISA plan. 481 U.S. at 52-56.

In its discussion of ERISA's civil enforcement scheme, the Court explained that "[t]he policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA." *Id.* at 54. And, in fact, this Court has found ERISA conflict preemption only where state law provides remedies not authorized by ERISA. See, *e.g.*, *Metropolitan Life Ins. Co.* v. *Taylor*, 481 U.S. at 58, 62-63 (1987) (state law claim seeking extracontractual damages); *Pilot Life*, 481 U.S. at 55 (same); *Ingersoll-Rand Co.* v. *McClendon*, 498 U.S. 133, 145 (1990) (same). No such concerns are implicated here. The remedy Moran sought was the payment that Rush Prudential had promised her, the same remedy guaranteed by ERISA section 502(a). By contrast, an award of punitive damages, as the plaintiffs sought in *Pilot Life*, is a substantively different remedy, at odds with ERISA's civil enforcement scheme. Respondent's claim arises under ERISA section 502(a), and she is not asserting that section 4-10(a) entitles her to legal or equitable remedies beyond those provided under ERISA.

The Illinois act mandates that medical-necessity disputes between the HMO (an insurer) and the primary care physician

of a patient (the insured) be subject to independent external review or arbitration. Respondent seeks enforcement of this determination through an ERISA action for benefits. This is a far cry from the assertion of either an alternative state-law *judicial* claim for benefits or additional substantive remedies (*e.g.*, punitive damages) under an ERISA plan, such as those at issue in *Pilot Life*. Respondent's action is not in conflict with ERISA's enforcement scheme.

Indeed, it is often acknowledged that ERISA's exclusive remedial scheme was modeled on that in section 301 of the Labor Management Relations Act, 29 U.S.C. § 185(a), and was intended to federalize ERISA remedies in the same way that section 301(a) has federalized remedies for violations of collective bargaining agreements. See, *e.g.*, *Pilot Life*, 481 U.S. at 54-56. Section 301(a) does provide an exclusive remedy for violations of collective bargaining agreements, but it does not prohibit the voluntary arbitration of such claimed violations subject to judicial enforcement under section 301(a).[11] In fact, employers and labor organizations routinely file section 301 actions to enforce or vacate arbitration awards in which federal courts defer virtually completely to the factual findings and legal conclusions of neutral labor arbitrators. See *Major League Baseball Players Ass'n* v. *Garvey*, 121 S. Ct. 1724 (2001).

By analogy here, section 502(a) of ERISA provides the exclusive cause of action for rights guaranteed under ERISA. But this exclusivity does not bar the arbitration of disputes between an HMO (the insurer) and the primary physician of a patient insured by the HMO (the insured) to determine the

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[11] *Cf. Lingle* v. *Norge Div. of Magic Chef, Inc.*, 486 U.S. 399, 413 n.12 (1988) ("as a general proposition, a state-law claim may depend for its resolution upon both the interpretation of a collective-bargaining agreement and a separate state-law analysis that does not turn on the agreement. In such a case, federal law would govern the interpretation of the agreement, but the separate state-law analysis would not be thereby preempted").

medical necessity of certain treatments, where that arbitration is mandated by a state insurance law. Those determinations may then be *enforced* through ERISA's exclusive enforcement provision. The Illinois law no more infringes upon ERISA's exclusive enforcement scheme than labor arbitration infringes upon section 301(a).

"If a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer's insurance contracts." *FMC Corp.*, 498 U.S. at 64. Such regulation then becomes part of the body of rules governing adjudication of ERISA enforcement actions and, in that context, plainly is not preempted. The alternative is not federal regulation, but *no regulation* of HMOs as insurers and health-care providers making medical-necessity determinations. As we now show, that situation would be insupportable, for such regulation is critical to patients and physicians in the managed-care context.

III. INDEPENDENT REVIEW OF HMO MEDICAL NECESSITY DECISIONS IS CONSISTENT WITH ERISA'S PRESERVATION OF THE TRADITIONAL STATE ROLE IN REGULATING INSURANCE AND HEALTH CARE AND FURTHERS ERISA'S PURPOSE OF PROTECTING PLAN PARTICIPANTS AND BENEFICIARIES THROUGH COMPLEMENTARY STATE AND FEDERAL REGULATION.

"Throughout our history the several States have exercised their police powers to protect the health and safety of their citizens." *Medtronic, Inc.* v. *Lohr*, 518 U.S. 470, 475 (1996). This case involves a state's use of its police powers to regulate the business of insurance in order to protect the health of its citizens. Because health issues are "primarily, and historically, . . . matter[s] of local concern," *Hillsborough County*, 471 U.S. at 719, this Court "presum[es] that state or local regulation of matters related to health and safety is not invalidated under the Supremacy Clause." *Id.* at 715.

ERISA's explicit savings of state insurance law and the presumption against preemption of a state's exercise of police power in the area of health provides the context for this case.

Responding to the exponential growth of managed care and the perceived subversion of medical judgment resulting from the commingling of the health-care and insurance functions, many states passed independent-review laws. As set forth above, far from manifesting a clear intention to preempt independent- review laws, Congress explicitly saved such laws from preemption through the insurance savings clause of ERISA, 29 U.S.C. § 1144(b)(2)(A). That congressional decision has permitted the development of laws that address the serious problems resulting from the emergence of managed care. And, the states have quite appropriately and expeditiously addressed these problems. As we now show, independent-review laws protect critical interests of insured patients and physicians in areas traditionally regulated by the states.

A. Independent-Review Laws Fill A Critical Need In Insurance Regulation.

As the AMA has informed Congress, "[t]he absence of independent review enables plans to make unfair and arbitrary decisions with virtually no consequences." *Employer Health Plan Accountability: Do Plan Participants Have Adequate Protections?: Hearing Before the House Subcomm. on Employer-Employee Relations, House Comm. on Educ. and the Workforce*, 106th Cong. 127 (1999) (statement of Timothy T. Flaherty, M.D., American Medical Association) ("*Flaherty Statement*"). The overall goal of independent-review laws, accordingly, is to ensure that persons enrolled in managed-care programs receive medically-necessary health care. Geraldine Dallek & Karen Pollitz, *External Review of Health Plan Decisions: An Update* 1 (Kaiser Family Foundation May 2000) ("*External Review Update*"). Such laws work toward that goal in a number of different ways.

Initially, independent-review laws help achieve the objective of having medical-necessity decisions made by physicians, not by insurance company administrators. "[M]edical necessity decisions are ultimately medical decisions and should continue to be treated as such. [They] must always be made in accordance with those generally accepted standards of medical practice that a prudent physician would follow when treating a patient." *Flaherty Statement* at 130. Independent external review helps ensure "that doctors will be reviewing doctor decisions," generally through a "faster" process. 147 Cong. Rec. H5204 (daily ed, Aug. 2, 2001) (statement of Rep. Johnson). As the AMA has testified, "a definition of medical necessity that is determined *by physicians* is one of the most critical factors in the review process." Susan Hershberg Adelman, M.D., AMA, *Statement to the Department of Labor Re: Proposed Claims Procedure Regulations* 3 (Feb. 17, 1999) (emphases in original omitted). Accordingly, the AMA has advocated, and many of the state laws provide, that independent review "be based on the medical judgment of a physician in the same specialty, actively practicing medicine in the same jurisdiction as the practitioner who is proposing or providing the reviewed service." *Id.* at 9 (emphases in original omitted).

In this regard, from the perspective of *amici*, a key benefit of independent review is that it protects and improves the relationship between patients and physicians. This is accomplished in major part by maintaining the primacy of physicians in the determination of what care a given patient should receive. As Senator Kennedy has explained, one major concern with managed care is that doctors and nurses no longer make critical medical decisions regarding treatment; instead, "accountants [who] do not have the training, do not know the patient, and do not know the complete medical circumstances surround[] the patient's case" are making those quintessentially medical decisions. 147 Cong. Rec. S6410 (daily ed. June 19, 2001) (statement of

Sen. Kennedy). Cf. 147 Cong. Rec. H5201 (daily ed. Aug. 2, 2001) (statement of Rep. Cooksey) (arguing that external review and other patient protections "go a long ways towards reestablishing the patient-physician relationship").

Independent-review laws also give physicians a forum in which to battle for the medical interests of their patients. The patient-physician relationship remains at the core of our health-care delivery system, and a patient's trust and belief in the integrity of the medical judgments made by his or her physician is critical. Independent-review laws allow physicians to protect and preserve the integrity of the patient-physician relationship in the managed-care context.

For similar reasons, independent-review laws will almost surely improve public perceptions of the health-care system. The growth of managed care has been accompanied by a corresponding growth in patient frustration, disappointment, and anger concerning their medical care. See Marc A. Rodwin, *Backlash as Prelude to Managing Managed Care*, 24 J. Health Pol., Pol'y & L. 1115, 1117-18 (Oct. 1999). Not surprisingly, "[e]xternal review of health plan decisions is seen by many as a significant component of state and federal patient protection proposals because it responds directly to consumer concerns about inappropriate denials of service." Helen Schauffler & Juliette Cubanski, *External Review of Health Plan Decisions Policy Brief, in California Health Policy Roundtable* 2 (Kaiser Family Foundation Jan. 1999) ("*Schauffler & Cubanski Policy Brief*"). "The use of independent review also helps to standardize a process that many consumers believe is subject to random denials of needed care." *External Review Update* at 18. In fact, "[h]ealth plan industry representatives stress[] [that] external review helps improve public perceptions about managed care." Karen Pollitz et al., *External Review of Health Plan Decisions: An Overview of Key Program Features in the States and Medicare* vi (Kaiser Family Foundation Nov. 1998) ("*External Review Overview*"); see also Tracy E.

Miller, *Center Stage on the Potential Protection Agenda: Grievance and Appeal Rights*, 26 J. L. Med. & Ethics 89, 95 (1998) ("Grievance and appeal procedures, especially those that include external review, may also bolster consumer confidence in the health plan. In addition, appeal procedures may prevent undertreatment. . . . .").

An additional benefit of independent-review laws is that they reduce the need for litigation. An August 2001 study examining the patient protection laws enacted in eight states noted that "[i]ndependent review processes operate in all eight states and were generally considered effective mechanisms for addressing most disputes over [managed care organization] coverage before injuries occur, limiting the need for litigation." Patricia Butler, *Key Characteristics of State Managed Care Organization Liability Laws: Current Status and Experience* 5 (Kaiser Family Foundation Aug. 2001). "External review is widely cited as a fair, impartial, and usually expeditious and cost effective way to resolve disputes." *External Review Update* at 1.

The experience of the State of Texas demonstrates that patients will utilize independent review in preference to the expensive and protracted process of litigation. 147 Cong. Rec., H4417-18 (daily ed. July 31, 2001) (statement of Rep. Pallone) ("What we are seeing is now that patients know that they can go outside the HMO and have an independent review of a denial of care. They are exercising that. They are not going to court because nobody wants to go to court and have litigation and spend money and go on and on for years. Nobody wants to do that, not the patients any more than the HMOs or the insurance companies."); see also 147 Cong. Rec. H3503 (daily ed. June 25, 2001) (statement of Rep. Green) (noting that Texas has had only 17 cases taken to

court in the four years since enactment of its external review law).[12]

Finally, many states use external review to conduct oversight of insurers, including "identify[ing] and correct[ing] a troubling pattern of decision-making regarding denials" of services and improving the overall quality of health care. See *External Review Update* at 18. The evidence is that "[e]xternal review appears to have a sentinel effect on health plan behavior." *External Review Overview* at 6 (emphasis omitted); *id.* at 50 ("external review enhances general oversight of health plans").[13]

B. State Regulation Of HMOs As Insurers Is Appropriate And Beneficial.

It is critically important that states continue to be able to mandate independent review of medical necessity decisions. As noted above, states have traditionally regulated both insurance and health care to protect the interests of its citizens. See *supra* at 8-9. "Part of traditional state authority to set standards for the insurance industry, state requirements for HMO grievance procedures have existed for many

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[12] *See also* Roderick B. Mathews, *The Role of ADR in Managed Health Care Disputes*, 54 Disp. Resol. J. 8, 11 (1999) ("The advantages of [alternative dispute resolution] are particularly compelling in the managed health care context. In addition to speed and efficiency, low cost, privacy/confidentiality, and non-precedential resolution, other positive considerations include: avoiding the win/lose confrontation of the courtroom and maintaining the possibility of continued business or personal relationships; ready accessibility; and enhanced perception of fairness through the use of independent neutrals.").

[13] Notably, experience in the States that have enacted independent review laws indicates that "the indirect as well as direct costs of external review" are "modest." *External Review Overview* at 52. In fact, in Texas, which has a particularly strong patients' protection law, "the costs of HMO premiums . . . have risen but *less* than the national average." 147 Cong. Rec. H4417 (daily ed. July 31, 2001) (emphasis supplied) (statement of Rep. Pallone).

years . . . ." Miller, *supra* at 91. Preempting state independent-review laws would both displace traditional state authority and leave insured patients unprotected.

States have the experience, flexibility, and familiarity with local conditions to determine the need for an independent-review law in their respective jurisdictions and to enact a law tailored to local requirements. At present, the displacement of state regulation would leave HMOs' medical-necessity determinations virtually unregulated. The enactment of patient protection legislation in the states underlines the importance of leaving states free to legislate in the areas of insurance and health care.

If Congress ultimately does act in this field, its action will have been informed by experience with "the merits of evolving state laws" addressing independent review. *Id.* at 95. See also 147 Cong. Rec. H5199 (daily ed. Aug. 2, 2001) (statement of Rep. Norwood) (acknowledging that patient protection bills have been languishing for six years in Congress). States have acted as laboratories for the regulation of HMOs acting as insurers by employing different forms of independent review. As state independent-review laws are adopted and analyzed, other states (and potentially Congress) could choose to model their laws after those that came before them. See *Schauffler & Cubanski Policy Brief* at 5 ("External review programs in many other states can serve as models for California in establishing an effective external review system."); Michael E. Ginsberg, *HMO Grievance Processes*, 37 Harv. J. on Legis. 237, 246-47 (2000) (using other states' experience to assess likely costs and benefits from new Maryland external review law). Recognizing the merits of the various states' independent review laws, Senator Edwards pleaded with his colleagues *not* to preempt state law because "State law has traditionally controlled these kinds of cases" and argued in favor of legislation "deferring almost entirely to the oversight of medical judgment that has traditionally been regulated by State law." 147 Cong. Rec.

S1368-69 (daily ed. Feb. 14, 2001) (statement of Sen. Edwards).

As this analysis makes clear, independent review laws lie at the heart of the traditional state regulation of insurance and health care and have many benefits for patients, physicians, and society as a whole. The strong presumption against preemption of traditional state police powers in combination with ERISA's insurance savings clause has allowed state regulation of managed care to emerge, including independent-review laws with their numerous attendant benefits. Section 4-10(a) is saved from preemption by the insurance savings clause of ERISA and does not conflict with ERISA's civil enforcement scheme. Illinois' power to regulate conduct at the confluence of the businesses of insurance and health care should be affirmed.

CONCLUSION

For the foregoing reasons, as well as those set forth in the respondent's brief, the decision below should be affirmed.

Respectfully submitted,

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IN THE

Supreme Court of the United States

RUSH PRUDENTIAL HMO, INC.,

Petitioner,

v.

DEBRA C. MORAN AND STATE OF ILLINOIS,

Respondents.

ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

BRIEF FOR CALIFORNIA CONSUMER HEALTH CARE COUNCIL; CALIFORNIA COALITION FOR ETHICAL MENTAL HEALTH CARE; CONGRESS OF CALIFORNIA SENIORS; AND HEALTH ADMINISTRATION RESPONSIBILITY PROJECT AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS

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INTEREST OF THE AMICI CURIAE

This brief is respectfully submitted on behalf of amici curiae California Consumer Health Care Council, California Coalition for Ethical Mental Health Care, Congress of California Seniors, and Health Administration Responsibility Project.[1] The interests of the amici curiae are as follows:

California Consumer Health Care Council (CCHCC), is a California non-profit, grassroots, volunteer-governed and operated, public benefit corporation. CCHCC acts as an advocate, in all available forums, to protect health care consumers from dangerous, deceptive, dishonest, unlawful or unfair practices. Ensuring that existing laws designed to protect consumers from improper acts and practices by managed care organizations and other health insurers ("MCOs") are fully enforced is central to CCHCC's purpose. CCHCC has among its constituents all California consumers affected by limitations on available redress and is dedicated to preserving and obtaining, through the courts, the power to hold MCOs accountable for improper conduct. The issues addressed in this case potentially impact health care regulation in California and the existing statutory provisions regulating managed care plans in this state (California Civil Code 3428) and are of immediate and substantial concern to this organization and its constituency.

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1. Letters from Petitioner and Respondents granting consent to the filing of this brief have been lodged with this Court. Pursuant to Rule 37.6, Amici disclose that no counsel for a party authored any part of this brief, nor did any person or entity other than Amici Curiae, its members, or its counsel make a monetary contribution to the preparation or submission of this brief.

California Coalition for Ethical Mental Health Care (CCEMHC) is a non-profit group composed of mental health patients and clients, family members and advocates, mental health professionals from all the disciplines licensed in California, and other interested members. The organization's mission is to advance access to quality, affordable mental health care through the coordinated efforts of mental health consumers and professionals. CCEMHC works to promote continuity of care, guarantee patients' right to make informed choices when selecting therapists and modalities of treatment, and eliminate the use of pernicious financial incentives which limit access to needed care. CCEMHC has an abiding interest in the issue presented in this case because it believes that health plans should be held accountable through strong regulation of the insurance industry and the unfettered right to seek redress through the legal system.

Congress of California Seniors (CCS), is a statewide non-profit education and advocacy organization dedicated to improving the life of seniors and their families. CCS devotes its efforts to legislative and consumer affairs that deal primarily with issues concerning older adults. CCS conducts research, analyzes issues and provides voter and consumer education to its members. Through an effective legislative committee, CCS initiates and monitors legislation, testifies at hearings and takes appropriate grass-roots action on pending and proposed legislation. When necessary, CCS initiates or joins in lawsuits to protect consumers. CCS supported the California HMO legislation (Civil Code section 3428) which contains an independent review requirement similar to that at issue in this case and which may be impacted by the decision here and is therefore vitally interested in the issues presented.

Health Administration Responsibility Project (HARP) is a non-profit organization that serves as an educational and informational resource for patients, doctors, and attorneys regarding managed care organizations, and seeks to enhance the quality of medical care benefits provided in the managed care setting. Because this case implicates a statutorily-required independent review process similar to that established under California law (Civil Code section 3428), HARP has an immediate interest in assuring that such protections remain viable and enforceable.

SUMMARY OF ARGUMENT

This Court's analysis of the interplay between state law remedies and ERISA's remedies provision in the second half of its decision in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) has been construed as standing for the following proposition: ERISA preempts *any* state law, even one regulating insurance, that provides a remedies scheme different than that afforded under ERISA. *New York State Conf. Of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 658 (1995); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 144 (1990); *Kanne v. Connecticut General Life Ins. Co.*, 867 F.2d 489, 494 (9th Cir. 1988); *Commercial Life Ins. Co. v. Superior Court (Juliano)*, 47 Cal. 3d 473, 480 (1988).

That fundamental premise should be re-examined. In fact, both the statutory interplay between ERISA's remedy provision and its preemption provision and the McCarran-Ferguson Act itself, mandate that a state law that regulates insurance and provides a remedy different than that provided under ERISA, is saved from ERISA preemption.[2]

2. For purposes of this brief, it will be assumed that health maintenance organizations, managed care entities, and the like, are, (Cont'd)

There are two reasons for this: First, ERISA's preemption provision, section 514(b)(2)(A), codified at 29 U.S.C. § 1144(b)(2)(A), explicitly provides that "*nothing in this subchapter* shall be construed to exempt or relieve any person from *any* law of any State which regulates insurance, banking or securities." (Emphasis added.) The subchapter referenced in that subdivision, *includes ERISA's remedies provisions*, i.e., ERISA section 502, 29 U.S.C. § 1132. Congress said it very plainly: *Nothing* in the subchapter — including the remedies provision — can be construed to exempt insurers from state law regulation. That must, therefore, necessarily include state laws regulating the remedies imposed on insurers.

Nor does this do any harm to Congress's intent to provide administrative protection to ERISA plans. As this Court acknowledged in *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), there is a distinction — and properly so — between ERISA

(Cont'd)

in fact, "in the business of insurance." *See Sarchett v. Blue Shield of Ca., Inc.*, 43 Cal. 3d 1, 3 n.1 (1987); In *Washington Physicians Service Ass'n v. Gregoire*, 147 F.3d 1039, 1045-1046 (9th Cir. 1998); *McEvoy v. Group Health Cooperative of Eau Claire*, 213 Wis. 2d 507, 570 N.W.2d 397 (1997); *Kentucky Assoc. of Health Plans, Inc. v. Nichols*, 227 F.3d 352, 364 (6th Cir. 2000); *Anderson v. Humana, Inc.*, 24 F.3d 889, 892 (7th Cir. 1994); *Ocean State Physicians Health Plan v. Blue Cross*, 883 F.2d 1101, 1107-1108 (1st Cir. 1989); California Managed Health Care Insurance Accountability Act of 1999, Statutes, Chapter 536, section 2; Joanne B. Stern, *Bad Faith Suits Against HMOs: Finally, a Breakthrough*, 1998, Whittier Law Review, Vol. 20, No. 2; Stern, *Bad Faith Suits: Are They Applicable to Health Maintenance Organizations?*, Summer 1983, West Virginia Law Review, Vol. 85, No. 5, p. 911. And any reference to "insurance" in this brief is intended to include HMOs and other managed care entities.

plans themselves and the insurance protection they buy. Allowing state laws to impose different remedies against *insurance companies* when *insurance companies* violate state insurance law does nothing to thwart Congress's intent to protect the administrative regulation of the plan itself.

Nor is there any basis for a claim by insurers or managed care plans that they would be harmed by varying state regulation where they issue their coverage to ERISA-preempted employer plans. This is because — very simply — they are subject to varying state regulation *anyway*. Indeed, every managed care company inevitably issues coverage to both non-ERISA plans (e.g., school districts, city, county, and state governments, churches) as well as ERISA plans. They are clearly subject to state regulation — and state law remedies — where they issue coverage to non-ERISA plans. They must necessarily, therefore, be perfectly capable of managing their business under state law auspices. Nothing changes simply because some of their coverage is issued to ERISA plans as well.

Second, the refusal to apply state law remedies that regulate insurance simply because the particular coverage is issued to an ERISA entity violates the express mandate of the McCarran-Ferguson Act which forbids any such federal regulation of the insurance industry. 15 U.S.C. § 1011, *et seq*. That statutory scheme forbids "inadvertent" preemption of state insurance laws by other federal legislation in the absence of congressional specification that the federal law is intended to regulate insurance. Since there is no such expression in ERISA — indeed, ERISA indicates just the opposite since the savings clause, ERISA section 514(b), 29 U.S.C. § 1144(b), expressly provides otherwise — the McCarran-Ferguson Act "trumps" ERISA and *no* state

law falling within the ambit of McCarran-Ferguson, even one that provides remedies different from ERISA, can be preempted by ERISA.

Because both the statutory structure of ERISA itself and the impact of the McCarran-Ferguson Act preclude preemption of state laws regulating insurance — even where that law provides for remedies not available under ERISA — the second half of the *Pilot Life* decision, to the extent it holds that any state remedy, even one regulating insurance, is preempted by ERISA, must be reversed.

ARGUMENT

I.

ERISA'S STATUTORY STRUCTURE PRECLUDES PREEMPTION OF STATE LAW REMEDIES THAT REGULATE INSURANCE

ERISA's civil enforcement provision, section 502, 29 U.S.C. § 1132, is subject to ERISA's preemption provision, section 514, 29 U.S.C. § 1144. Nothing in the express provisions of the civil enforcement section states that the terms and provisions of that section do, or are intended to, establish or provide a preemption power distinct from the preemption provision itself. Indeed, section 1132 is utterly silent as to the preemptive effect of its civil enforcement scheme.

The only preemption language in ERISA, in fact, is contained in section 1144. The actual structure of ERISA's provisions is unambiguous: None of the definitional, substantive, procedural or other provisions contain any preemption provisions at all. Thus, it was obviously the

drafters' intent that section 1144 establish and set forth the preemptive power of the act itself as a whole, as well as the preemptive effect of each individual provision of the act.

Thus, the determination of whether the civil enforcement provision of the act (section 1132) preempts a state law remedy or enforcement scheme is controlled by the preemption analysis applicable under section 1144.

Under section 1144(a), the provisions of the act, including the civil enforcement section, "supersede any and all State laws insofar as they . . . relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title." This is commonly referred to as the "preemption provision."

Section 1144(b) is entitled "Construction and application" and delineates how section 1144 is to be applied. Section 1144(b)(2)(A) is commonly referred to as the "savings clause" and provides:

> Except as provided in subparagraph (B), *nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities.*

(Emphasis added.)

The conclusion that the civil enforcement scheme established under 1132 is subject to the preemption rules set forth in section 1144 is mandated by the fact that the savings clause expressly states that it applies to *all* the provisions *of the subchapter*. Sections 1132 and 1144 are both contained *in the same subchapter*: Title 29, Chapter 18, Subchapter I.

Thus, Congress expressly provided that ERISA's civil enforcement provisions are not to exempt or relieve any person from any law which regulates insurance — even where that law provides an alternative remedy scheme.

Notably, subjecting *insurers* to state law regulatory remedies for improper claims processing under policies issued to ERISA plans does not imperil Congress's intent to protect ERISA *plans* from liability beyond the scope of section 1132. As this Court expressed in *Travelers*, Congress's intent in establishing its exclusive civil enforcement scheme was to protect *plans* from differing standards among the states which would subject the *plan* to varying administrative requirements. *Travelers*, *supra*, 514 U.S. at 656-657. Congress also wanted to protect the financial integrity of the plan's assets by assuring that the plan's funds would not be depleted by awards of extra-contractual damages under varying state laws. *Pohl v. National Benefits Consultants*, 956 F.2d 126, 128 (7th Cir. 1992).

And if the state laws regulating claims processing applied to the *plan*, that analysis would be valid. But where the state law applies to the practices and procedures employed by *insurance companies or managed care entities*, even when they are processing claims under policies issued to ERISA plan beneficiaries, those rationales break down:

First, the insurer, with respect to claims under its non-ERISA policies (including policies issued to government plans and church plans which are exempted from ERISA preemption, *see* 29 U.S.C. § 1003(b)), is already subject to varying state law administrative requirements and must conform its claims processing to different laws among the states in which it conducts business. Requiring the insurer

to do the same with respect to the processing of claims under ERISA policies adds nothing to the burden the insurer already bears.

Second, state laws imposing damages beyond those permitted under ERISA against the *insurance company* does nothing to deplete the assets of the *ERISA plan*. Since state laws regulating insurance can be applied only to an insurer engaged in the business of insurance, and since insurers pay claims submitted under policies issued by them out of their own general accounts and do not pay claims out of the *plan's* ERISA account, any damages awarded can necessarily affect only the *insurer's* general account. As such, the *plan's* account is not impacted and cannot be depleted or affected by the state law in abrogation of section 1132.

And, finally, this Court has already rejected the argument that ERISA "relates to" a law simply because the law may increase the cost to the ERISA plan of purchasing products. *Travelers*, *supra*, 514 U.S. at 659-660. Thus, the fact that an insurer who has higher costs from imposition of remedies under state law may have to increase premium costs does not warrant ERISA preemption.

Indeed, this Court's decision in *FMC Corp. v. Holliday*, 498 U.S. 52 (1990) highlights the distinction between regulation of plans and regulation of insurers. In *FMC*, this Court strongly distinguished between regulatory provisions applicable to a self-insured plan and a plan which fulfilled its fiduciary obligation to provide benefits through the purchase of insurance:

> *An insurance company that insures a plan remains an insurer for purposes of state laws* "purporting

> to regulate insurance" after application of the deemer clause. *The insurance company is therefore not relieved from state insurance regulation.* [¶] Our decision, we acknowledged, "results in a distinction between insured and uninsured plans, leaving the former *open to indirect regulation while the later are not.*" . . . "*By doing so, we merely give life to a distinction created by Congress in the 'deemer clause,'* a distinction Congress is aware of and one it has chosen not to alter." [¶] By recognizing a distinction between insurers of plans and the contracts of those insurers, *which are subject to direct state regulation*, and self-insured employee benefit plans governed by ERISA, which are not, we observe Congress's presumed desire to reserve to the States the regulation of the "business of insurance."

Id. at 61-63; emphasis added.

This Court also went on to note:

> As we have pointed out . . . , the savings clause retains the *independent effect of protecting state insurance regulation of insurance contracts purchased by employee benefit plans.* [¶] . . . Our interpretation of the deemer clause makes clear that *if a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer's insurance contracts*; if the plan is uninsured, the State may not regulate it. As a result, *employers will not face "conflicting or inconsistent State and local regulation of employee benefit plans.*"

Id. at 64; emphasis added.

As acknowledged by this Court in *FMC*, there is a distinction between regulation of a plan and regulation of an insurance company that issues coverage to a plan. That distinction does not, and should not, fall apart simply because the state law regulation of the insurance company imposes remedies that differ from ERISA's — because, again, it is the insurer being regulated, not the plan.

Since ERISA's own preemption structure mandates that a state law regulating insurance be saved from preemption, even with respect to the part of the subchapter containing the remedies provision, statutory construction principles require that the remedies provision be subjugated to the preemption provision. As such, ERISA's remedies scheme must give way to any state insurance regulation providing remedies different from those in ERISA.

II.

APPLYING ERISA'S REMEDY LIMITATIONS TO INSURERS VIOLATES THE MCCARRAN-FERGUSON ACT

That Congress intended ERISA's remedy structure to be subjugated to state insurance law regulation is wholly logical and consistent with the fact that to do otherwise would violate the McCarran-Ferguson Act, 15 U.S.C. § 1011, *et seq*. Indeed, to construe section 1132 and section 1144 any other way would conflict with — and be overridden by — McCarran-Ferguson. This is because McCarran-Ferguson expressly provides that "[n]o Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance. . . . unless such Act *specifically relates* to the business of insurance." 15 U.S.C. § 1012(b); emphasis added.

As expressed by this Court in *Securities and Exchange Commission v. National Securities, Inc.*, 393 U.S. 453 (1969), the purpose of the McCarran-Ferguson Act was to assure that activities of insurance companies in dealing with their policyholders would remain *subject to state regulation*. And, as noted by the Ninth Circuit in *Merchants Home Delivery Service, Inc. v. Frank B. Hall & Co., Inc.*, 50 F.3d 1486 (9th Cir. 1995), *cert. denied*, 516 U.S. 964, 116 S. Ct. 418 (1995), the McCarran-Ferguson Act was specifically designed to prevent "inadvertent" preemption of state insurance laws by federal statutes of general application. Congress thus established its "inverse preemption" approach — meaning that a federal law that would otherwise preempt the state insurance law is itself preempted by McCarran-Ferguson, thus leaving the state law intact and enforceable, despite the otherwise expansive preemptive effect of the federal law.

The McCarran-Ferguson Act thus precludes *any* federal legislation from preempting state laws regulating the business of insurance *unless* the federal legislation is, itself, directly related to the business of insurance. *Merchants Home Delivery, supra.*

Thus, a federal statute cannot be enforced so long as the four following prongs are met:

(1) The federal statute does not "specifically relate" to the business of insurance;

(2) The acts challenged under the federal statute constitute the business of insurance;

(3) The state has enacted laws regulating the challenged acts; and,

(4) The state law would be superseded, impaired or invalidated by application of the federal statute. (*Id.*)

Assuming the state law at issue is one similar to that here, i.e., regulating the determination of whether a medical treatment is covered as medically necessary under the coverage provided through imposition of an independent review process, the question, then, is whether applying 29 U.S.C. § 1132 (ERISA's civil enforcement section) would violate the McCarran-Ferguson Act's prohibitions and would thus be unenforceable. Addressing the McCarran-Ferguson Act's elements seriatim:

A. Does ERISA specifically relate to the business of insurance?

As noted by this Court in *Barnett Bank of Marion County, N.A. v. Nelson*, 517 U.S. 25, 116 S. Ct. 1103 (1996), using the bankruptcy laws as an example, many federal statutes with potentially preemptive effect on state insurance laws use general language that does not appear to specifically relate to insurance. Where those statutes conflict with state law enacted for the purpose of regulating insurance, the McCarran-Ferguson Act's "antipreemption rule" will apply to prohibit federal preemption of those state laws and the state laws apply.

Obviously, ERISA does not relate, either generally or specifically, to the business of insurance. It relates to the business of pension plans and employee benefits. While employee benefits may be provided through the purchase of insurance, and ERISA would thus arguably have a potentially preemptive effect on state insurance laws, the effect would be collateral at best, much like bankruptcy laws might affect

the business of insurance, and could not rationally be construed as a law *specifically related* to the business of insurance.

In fact, the Ninth Circuit specifically held that ERISA fell within the preemption provisions of the McCarran-Ferguson Act, thus necessarily determining that it was not a law specifically related to the business of insurance. *Hewlett-Packard Co. v. Barnes*, 571 F.2d 502 (9th Cir. 1978), *cert. denied*, 439 U.S. 831, 99 S. Ct. 108 (1978).

B. Do the acts challenged under the federal law relate to the business of insurance?

The question here is whether the determination of whether a particular procedure is medically necessary, and therefore covered under the insurance policy, "relates to the business of insurance." As noted by this Court in one of its cases interpreting the "business of insurance" component of the McCarran-Ferguson Act, a state statute aimed at *protecting or regulating* the relationship between the insurance company and policyholder, *directly or indirectly* are laws regulating the business of insurance. *Securities and Exchange Commission v. National Securities, Inc.*, 393 U.S. 453, 89 S. Ct. 564 (1969).

And where the state itself determines that an activity constitutes the "business of insurance," the federal courts will give great weight to that determination. *Royal Drug Co., Inc. v. Group Life & Health Ins. Co.*, 556 F.2d 1375 (5th Cir. 1977), *affirmed*, 435 U.S. 903, 98 S. Ct. 2017 (1978). Thus, if the legislation itself provides that the intent of the statute is to regulate the business of insurance, that will require the federal courts to give great weight to that

conclusion. Under the California law providing for independent review of a health plan's medical necessity determinations, the Legislature expressly found that the managed care entities were, in fact, engaged in the business of insurance. California Managed Health Care Insurance Accountability Act of 1999, Statutes, Chapter 536, section 2.

Furthermore, in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 743-744 (1985), this Court essentially provided that the core issues in the "business of insurance" determination included the type of policy, its reliability, its interpretation, and its enforcement. Obviously, a state regulatory statute that expressly deals with the *enforcement* of the insured's policy rights falls squarely within the McCarran-Ferguson Act's provisions.

Other cases also support that conclusion. The court in *Lowe v. Aarco-Am., Inc.*, 536 F.2d 1160 (7th Cir. 1976), in concluding that the business of insurance includes setting insurance rates and terms for financing premiums as well as disclosure of such terms, stated that the "business of insurance" includes more than "just" questions of validity and enforceability of insurance policies. Obviously, a statute regulating the appropriate handling of coverage determinations, and requiring that coverage promised under the plan be provided, specifically relates to the *enforceability* of policies.

Also, in *Klamath-Lake Pharmaceutical Ass'n v. Klamath Medical Service Bureau*, 701 F.2d 1276 (9th Cir. 1983), *cert. denied*, 464 U.S. 822, 104 S. Ct. 88 (1983), the court held that Oregon's regulations banning unfair or deceptive acts or practices constituted regulation of the business of insurance under the Act. And in *Freier v. New York Life Ins.*

Co., 679 F.2d 780 (9th Cir. 1982), the court held that the relationship between an insurer making payments to a disabled employee under a group term policy issued to the employer was an activity that fell within the definition of business of insurance.

And this law falls within the protection of the McCarran-Ferguson Act even under the standard mantra that, in order to be considered part of the business of insurance, the targeted activity must have the effect of transferring or spreading policyholder's risk, the practice must be an integral party of a policy relationship and the practice must be limited to entities within the insurance industry. *Ticor Title Ins. Co. v. F.T.C.*, 998 F.2d 1129 (3d Cir. 1993), *cert. denied*, 510 U.S. 1190, 114 S. Ct. 1292 (1994).

First, of course, if an insurer refuses to cover a treatment under the policy on the grounds that it is not medically necessary and therefore not covered when, in fact, it is, the insurer is directly impacting the spreading of policyholder risk. Because the insurer is not paying on covered claims, it is leaving the policyholder bearing a risk that the insurer had accepted a premium to assume.

And, obviously, the payment — or nonpayment — of claims is the very thing contracted for by the insured and is thus integral to the policy relationship.

Lastly, of course, only insurers pay claims under insurance policies and since payment of the claims represent the ultimate outcome of promising indemnification for contingent risks, it is relevant only to the insurance industry.

Thus, legislation regulating whether a claim must be paid falls within the parameters of the business of insurance.

C. Has the state enacted laws regulating the challenged acts?

That is the starting premise, both with the Illinois law under consideration and the similar California law that may be impacted by the Court's decision in this case.

D. Would the state law be superseded, impaired or invalidated by application of the federal statute.

This prong, too, is well met. Obviously, if ERISA's civil enforcement scheme were applied to limit the damages recoverable under the state law provisions regarding the coverage or claims to be paid under the health care policy, it would do all three: supersede, impair and invalidate the state law.

Thus, the straightforward application of the McCarran-Ferguson Act precludes ERISA's preemption of a state law regulating claims determinations. That being the case, ERISA preemption of the state law regulating insurance on the basis that the state law's remedies provisions conflict with ERISA's remedies provisions is forbidden under the McCarran-Ferguson Act.

CONCLUSION

Because ERISA's statutory structure expressly provides that all state laws regulating insurance supercede even ERISA's own remedies provisions, and because any attempt to preempt state insurance laws would violate the McCarran-Ferguson Act, any conclusion to the contrary violates both ERISA and McCarran-Ferguson. That being the case, this Court should make manifestly clear that the mere fact that a state law providing a remedies scheme different from that set forth in ERISA is not preempted by ERISA where that state law is regulating the insurer rather than the plan.

Respectfully submitted,

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In The

Supreme Court of the United States

RUSH PRUDENTIAL HMO, INC.,

Petitioner,

v.

DEBRA C. MORAN and STATE OF ILLINOIS,

Respondents.

On Writ Of Certiorari
To The United States Court Of Appeals
For The Seventh Circuit

BRIEF OF UNITED POLICYHOLDERS AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENTS

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QUESTION PRESENTED

Whether a law which is saved from preemption under the terms of the saving clause of the Employee Retirement Income Security Act of 1974 ("ERISA"), ERISA Section 514(b)(2)(A), 29 U.S.C. § 1144(B)(2)(A), is nonetheless preempted because it provides a remedy other than those enumerated in ERISA's remedial provision. ERISA § 502, 29 U.S.C. § 1132.

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INTEREST OF THE *AMICUS CURIAE*

United Policyholders is a national, not-for-profit educational organization whose mission is to educate the public, legislators and the courts on insurance issues and consumer rights, and to assist policyholders in securing prompt and fair insurance settlements.[1] As explained in the Summary of Argument, the resolution of the issue presented in this case is of great importance to United Policyholders and its members because of its potential application to a wide range of laws affecting employees insured through an ERISA plan.

SUMMARY OF ARGUMENT

The principal argument set forth by petitioner and its supporting *amici* is that Section 4-10 of the Illinois Health Maintenance Organization Act provides a remedy different than those remedies set forth in ERISA Section 502, 29 U.S.C. § 1132. *A fortiori,* they argue, even though the law may be saved from preemption under ERISA's saving clause, the law conflicts with ERISA's exclusive remedies and therefore is preempted under this Court's holding in *Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41 (1987). They also argue that the subject statute does not even fall within the saving clause and therefore is subject to ERISA's preemption clause.

We anticipate that respondents will thoroughly address their contentions that (1) the Illinois law does fall

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[1] United Policyholders, as *amicus curiae,* has obtained the consent of both the Petitioner and the Respondents to submit this brief. The letters of consent have been lodged with the Clerk of the Court. No counsel for any party in this case authored this brief in whole or in part, and no person or entity other than United Policyholders and its members made any monetary contribution to the preparation or submission of this brief.

within the saving clause and (2) that it does not provide an additional remedy, and therefore is not even subject to the *Pilot Life* claim. This brief does not address those questions. We only address the principal question whether ERISA's saving clause defeats a claim that the law is preempted because it provides a remedy other than those set forth in ERISA Section 502.

Petitioner relies almost exclusively upon *Pilot Life*. Yet, this Court has recently pointed out that *Pilot Life* does not address Section 502's impact on laws encompassed by the saving clause. Rather, the issue presented in this action is an open question. *See UNUM Life Insurance Co. of Am. v. Ward*, 526 U.S. 358, 377 n.7 (1999) ("The case therefore does not raise the question whether § 502(a) provides the sole launching ground for an ERISA enforcement action"; *Pilot Life's* holding was "in the context" of a law which was not saved from preemption). Further, in *Franchise Tax Board of Cal. v. Construction Laborers Vacation Trust for Southern Cal.*, 463 U.S. 1, 25 (1983), this Court clearly held that "[the saving clause] makes clear that Congress did not intend to preempt entirely every state cause of action relating to" ERISA plans.

When one looks at the clear language of ERISA, its legislative history and the language of this Court's decisions, the conclusion is inescapable that ERISA does not preempt state insurance laws, such as Section 4-10 of the Illinois law, merely because they provide remedies other than those set forth in ERISA's Section 502. Further evidence for this conclusion is that ERISA provides that petitioner is not a proper party to this ERISA action. 29 U.S.C. § 1132(d)(2). Rather, ERISA's remedies were designed to address the ability to redress abuses in pension plans, not insurance disputes. Accordingly, under ERISA, an insured, such as Moran, would be limited to an

action against the welfare benefit plan itself. Congress did not intend this result for insurance disputes. It intended that States were free to continue to regulate and provide remedies appropriate to the regulation of insurance and that Moran is therefore free to pursue petitioner on her state-law claim. Moreover, because the claim at issue is saved from preemption, this matter was improperly removed to the federal district court and should be remanded to the State court where the action originated.

United Policyholders further believes that this Court's decision in *Pilot Life* has resulted in great confusion and the denial of appropriate redress to innumerable insureds and that this Court should revisit its holding in *Pilot Life*.

The issue before the Court is of great importance to United Policyholders, which is devoted to protecting the rights of insureds in a wide variety of contexts, including life, health and disability insurance as well as property and liability insurance. There are numerous actual and potential state insurance laws which fall squarely within the saving clause, but whose enforcement has been nullified by courts which have interpreted this Court's precedents as barring any such laws which provide a remedy other than those set forth in ERISA.[2] Thus, the determination in this case of whether ERISA's remedial provisions bar enforcement even of those laws which are explicitly

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[2] *See, e.g., Kanne v. Connecticut General Life Ins. Co.*, 867 F.2d 489 (9th Cir. 1988), *cert. denied*, 492 U.S. 906 (1989); *Ramirez v. Inter-Continental Hotels*, 890 F.2d 760, 763-64 (5th Cir. 1989); *In Re Life Ins. Co. of N. Am.*, 857 F.2d 1190, 1194 (8th Cir. 1988); *but see Franklin H. Williams Ins. Trust v. Travelers Ins. Co.*, 50 F.3d 144, 151 (2nd Cir. 1995) ("It would be quixotic to rule that a claim under a state statute that is saved from ERISA preemption . . . may nonetheless be enforced only via ERISA provisions and remedies").

saved from preemption has ramifications far beyond the particular law in question here.[3]

An additional concern of United Policyholders is that, in the event this Court does find that the law in question is preempted, that it not foreclose the application of other laws, which are not preempted. In particular, petitioner here claims that Section 4-10 of the Illinois law is merely a substitute procedure for an ERISA participant's right to institute a civil action under Section 502(a)(1)(B). However, other state laws exist which would not be substitutes for, but would be in addition to the claims available under ERISA. These claims may well

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[3] For example, many states provide either a common law remedy against insurers who violate the covenant of good faith and fair dealing where, unlike the state law at issue in *Pilot Life*, the claim is available solely against the insurance industry. *See, e.g., Kransco v. American Empire Surplus Lines Ins. Co.*, 23 Cal.4th 390, 400, 2 P.3d 1 (2000) ("The availability of [common law] tort remedies in the limited context of an insurer's breach of the covenant advances the social policy of safeguarding an insured in an inferior bargaining position who contracts for calamity protection, not commercial advantage"); *Rogers v. Tecumseh Bank*, 756 P.2d 1223, 1226 (Okla. 1988) ("the implied-in-law duty of good faith and fair dealing [is imposed] on the insurer because of the special purpose for obtaining insurance: An insurer has a special relationship to its insured and has special implied-in-law duties toward the insured"). Additionally, in many States insureds may maintain a private right of action under the state's Unfair Insurance Practices statute. *See Humana Inc. v. Forsyth*, 525 U.S. 299, 312 (1999) (referencing private right of action under Nevada Unfair Insurance Practices Act); Stephen S. Ashley, *Bad Faith Actions: Liability And Damages* § 9:02, at 9-3 through 9-10, & n.38 (2d ed. 1997); *see also Hill v. Blue Cross Blue Shield of Alabama*, 117 F.Supp.2d 1209 (N.D. Ala. 2000) (finding state common law bad faith claim saved and no longer preempted under reasoning of *Ward*, 526 U.S. 358); *Lewis v. Aetna U.S. HealthCare, Inc.*, 78 F.Supp.2d 1202 (N.D. Okla. 1999) (same).

complement rather than conflict with ERISA's remedial scheme. Saving such claims from preemption would permit the insured appropriate relief by being able to pursue both a Section 502(a)(1)(B) action together with other state-law claims which are aimed at the insurance industry.[4]

ARGUMENT

I. ERISA'S EXPRESS PREEMPTION CLAUSE CONTROLS OVER ANY CLAIM OF IMPLIED PREEMPTION ARISING OUT OF ERISA SECTION 502.

A. Preface

ERISA was enacted as a pension reform bill intended to protect the retirement benefits of workers. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983); 29 U.S.C. § 1001(b). Protecting "the continued well-being and security of millions of employees and their dependents" was an express Congressional declaration of policy. 29 U.S.C. § 1001. ERISA comprehensively regulates pension plans. Importantly, ERISA does not comprehensively regulate the terms of non-pension employee benefit plans.[5]

In addition to its substantive provisions, ERISA includes a preemption clause, which provides that, "except as provided in [the saving clause] the provisions of this title . . . shall supersede any and all State laws insofar as they . . . relate to any employee benefit plan. . . . " ERISA § 514(a), 29 U.S.C. § 1144(a). This Court

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[4] *See* note 3, *supra*, and note 46, *infra*.

[5] *See* Donald T. Bogan, *Protecting Patient Rights Despite ERISA: Will the Supreme Court Allow States to Regulate Managed Care?* 74 Tul. L. Rev. 951 (2000) (hereafter, Bogan, *Protecting Patient Rights*).

has described the preemption clause as "expansive."[6] However, the preemption clause is modified by the saving clause, which declares " . . . nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance. . . . " ERISA Section 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). This saving clause is "phrased with similar breadth" as the preemption clause.[7]

In addition to ERISA's express preemption language, this Court has held that ERISA's comprehensive civil enforcement provisions, detailed in ERISA Section 502, suggest that Congress intended all claims arising from an ERISA-governed employee benefit plan which fall within the ambit of ERISA Section 502 must be pursued exclusively through ERISA.[8] However, this Court has explained that it has not yet determined whether Congress's express exemption from preemption for state laws regulating insurance supersedes any inference of preemption arising from ERISA Section 502 when the state-law remedy at issue provides a remedy aimed specifically at the insurance industry. *Ward*, 526 U.S. at 377.

As the Court approaches this statutory interpretation question, several guiding principles previously established in the Court's ERISA jurisprudence will apply. Like

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[6] *See New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995); *Pilot Life*, 481 U.S. at 46.

[7] *Ward*, 526 U.S. at 363 ("[P]re-emption is substantially qualified by an 'insurance saving clause,' . . . which broadly [saves state insurance laws]. . . . "); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 740-741 (1985) (" . . . [W]hile the general pre-emption clause broadly preempts state law, the saving clause appears broadly to preserve the States' lawmaking power over much of the same regulation").

[8] *See Pilot Life*, 481 U.S. 41.

all issues of statutory construction, preemption claims turn on Congress's intent.[9] The Court must "begin with the language employed by Congress and the assumption that the ordinary meaning of that language accurately expresses the legislative purpose."[10] Further, the Court must also presume that Congress did not intend to preempt areas of traditional State regulation.[11]

Not only is insurance an area of traditional State regulation, but Congress has specifically designated insurance as a special area of State regulation to be zealously protected from federal regulation. The McCarran-Ferguson Act provides that federal laws shall not be interpreted to supersede state laws regulating the business of insurance. 15 U.S.C. § 1012(b); *Humana, Inc. v. Forsyth*, 525 U.S. 299, 306 (1999). "Congress' 'primary concern' in enacting McCarran-Ferguson was to ensure the States' continued ability to regulate the business of insurance." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 744 n.21 (1985). And the ERISA saving clause was designed to preserve the McCarran-Ferguson Act's reservation of the business of insurance to the States. *Id.*;

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[9] *See Travelers*, 514 U.S. at 655.

[10] *FMC Corp. v. Holliday*, 498 U.S. 52, 57 (1990), *citing Park'N Fly, Inc. v. Dollar Park and Fly, Inc.*, 469 U.S. 189, 194 (1985).

[11] *See Travelers*, 514 U.S. at 655 ("We have never assumed lightly that Congress has derogated state regulation, but instead have addressed claims of pre-emption with the starting presumption that Congress does not intend to supplant state law. Indeed, in cases . . . where federal law is said to bar state action in fields of traditional state regulation, we have worked on the 'assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress' " (citations omitted)).

Ward, 526 U.S. at 375 n.5. Moreover, "[t]here is no discussion in [the legislative] history [of ERISA] of the relationship between the general pre-emption clause and the saving clause, and indeed very little discussion of the saving clause at all." *Metropolitan Life*, 471 U.S. at 745. This Court therefore "decline[d] to impose any limitation on the saving clause beyond those Congress imposed in the clause itself. . . . If a state law 'regulates insurance,' . . . it is not pre-empted. Nothing in the language, structure, or legislative history of the Act supports a more narrow reading of the clause. . . . " *Id.* at 746-47.

Given the unambiguous language of the saving clause and the strong prohibitions against preemption of state insurance laws, the conclusion that a state law that falls within the saving clause is still preempted would require a clear and manifest expression of Congressional intent. Yet, as extensively discussed below, there is nothing in the statutory history of ERISA even to suggest such an intent, let alone a clear and manifest intention.

B. *Pilot Life* Does Not Control The Question Presented In This Action Because The State Law At Issue In *Pilot Life* Was Not A Law Regulating Insurance.

In *Pilot Life*, this Court held that ERISA preempted a state-law claim for tortious breach of contract arising from an insured ERISA disability benefits plan. The Court found that the state-law claim related to ERISA and was not saved from preemption because the Mississippi law was not aimed specifically at the insurance industry.[12] As

[12] *But cf., Humana*, 525 U.S. 299. This holding in *Pilot Life* appears to be in direct conflict with the Court's later opinion in *Humana* where the Court assumed, without analysis, that the very same law in Nevada – a state common law tort remedy for bad faith breach of an insurance contract – was within the ambit

part of the Court's analysis of the saving clause issue in *Pilot Life*, and in accordance with the views of the Solicitor General, it relied upon the structure and legislative history of the civil enforcement provisions contained in ERISA Section 502 to bolster its conclusion that Congress intended ERISA to preempt the state-law remedy at issue in that action. *Pilot Life*, 481 U.S. at 51-52.

Critically, the reasoning of the Court applied only to laws of general application and does not logically extend to laws that fall within the saving clause. Further, in the recent case of *Ward*, 526 U.S. 358, 377 n.7, the Solicitor General specifically pointed out that the Section 502 implied preemption analysis it presented in *Pilot Life* would not apply in a case where the state-law remedy at issue was a state law regulating insurance. The limited application of *Pilot Life's* Section 502 implied preemption analysis is reflected in the Court's final sentence: " . . . [W]e conclude that Dedeaux's state law suit asserting improper processing of a claim for benefits under an ERISA-regulated plan is not saved by [the saving clause] *and therefore* is pre-empted by [the preemption clause]." *Pilot Life*, 481 U.S. at 57 (emphasis added).

In noting that ERISA's remedies were intended to be exclusive, the *Pilot Life* Court relied on two factors: (1) the structure of ERISA itself and (2) reference in the legislative history of ERISA to the preemptive scope of Section 301 of the Labor-Management Relations Act of 1947 ("LMRA"), 29 U.S.C. § 185. Regarding the structure of ERISA, the Court held that the ERISA remedies represented a comprehensive enforcement scheme, which, in light of ERISA's broad preemption clause, was intended to be exclusive. The Court determined that parties were

of the McCarran-Ferguson Act. *Id.* at 311-313. *See* discussion in text at Section D, *infra*.

not "free to obtain remedies under state law that Congress rejected in ERISA." *Pilot Life*, 481 U.S. at 54.

While this conclusion can be applied to generally applicable state-law remedies, such as was before the Court in *Pilot Life*, or more importantly, to laws affecting pension benefits, the same is not true of laws which fall within the specific Congressionally-carved exception, which saves laws regulating insurance. Congress did not "reject" remedies specifically provided for within the confines of the saving clause. On the contrary, such laws were specifically saved, not rejected. Further, the saving clause is fundamental to the structure of the Act. It provides that " . . . *nothing* in this subchapter shall be construed to exempt or relieve any person from *any* law of any State which regulates insurance. . . . " 29 U.S.C. § 1144(b)(2)(A). Not only are the remedies contained in the same subchapter as the saving clause (remedies in 29 U.S.C. § 1132, saving clause in 29 U.S.C. § 1144), but the saving clause is in the very same statute as the preemption clause (29 U.S.C. § 1144). As such, the structure of ERISA cannot serve as the clear and manifest intent of Congress required to override the clear terms of the saving clause itself and, as set forth at length below, there is nothing in the legislative history of the Act to support such a conclusion. Thus, it is illogical to transfer this Court's discussion of the structure of ERISA in *Pilot Life* to the entirely different context of a law that the very structure of the Act provides is "saved" from preemption.

The second claimed factor supporting the *Pilot Life* conclusion is that the Conference Report contained reference to the LMRA. 481 U.S. at 55. The *Pilot Life* Court determined that this statement reflected Congress' intent to compare ERISA's preemptive effect with the powerful preemptive force of Section 301 of the LMRA. *Id.* Once again, this may apply with regard to laws of general

applicability or laws relating to pension benefits; however, it has no bearing with respect to a law that falls within the saving clause. The LMRA has no saving clause and thus is not comparable legislation when addressing a law that is specifically saved from preemption. Indeed, this Court has made this very point.

This Court has repeatedly pointed out that the saving clause is just as broad as the preemption clause. *Ward*, 526 U.S. at 363; *Metropolitan Life*, 471 U.S. at 733. Thus, the remedial clause cannot serve to trump the saving clause simply because of reference in the legislative history to the LMRA.

> The phrasing of § 502 [ERISA's remedial provision] is instructive. It does not purport to reach every question relating to plans covered by ERISA . . . *Furthermore, § 514(b)(2)(A) of ERISA [the saving clause] makes clear that Congress did not intend to preempt entirely every state cause of action relating to such plans.* With important, but express limitations, it states that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." *In contrast*, § 301 (a) of the LMRA applies to all "suits for violation of contracts between an employer and a labor organization representing employees in an industry effecting commerce . . . or between any such organizations."

Franchise Tax Board v. Construction Laborers Vacation Trust for Southern Cal., 463 U.S. 1, 25 (1983) (emphasis added).

Even the *Pilot Life* decision makes this clear. In citing to the legislative history, the Court quoted one of the bill's sponsors, Senator Williams as follows: *"[W]ith the narrow exceptions specified in the bill*, the substantive and enforcement provisions of the conference substitute are intended to preempt the field. . . . " 481 U.S. at 46

(emphasis added). Manifestly, the saving clause is the principal exception.[13] Moreover, Senator Williams' statement, as well as those of the other sponsors of the bill,[14] were made in the context of the intended purpose of the Act. ERISA was intended as pension reform legislation. It did not intend to deal with or replace state laws regulating insurance. ERISA is silent with regard to any meaningful regulation of insurers. Instead, it saves to the States the continuing responsibility to regulate insurers.

Field preemption "strips the states of all regulatory authority in the defined field and is normally inferred by the courts only when Congress has comprehensively regulated the subject area or when the subject is peculiarly with the federal domain."[15] Yet, ERISA's comprehensive regulations are entirely directed at pension benefits, and insurance is a field in which regulation is traditionally left to the states. Bogan, *Protecting Patient Rights, supra* note 15, 74 Tul. L. Rev. at 974-75. Thus, to imply a Congressional intent to preempt the field of nonpension benefits is to void all state regulation, while failing to replace it with any federal regulation, let alone comprehensive federal regulation. It is apparent that the very purpose of the saving clause was to avoid such a regulatory void by

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[13] Reference in Senator Williams' remarks to the "narrow" exception is "far too frail [to] support" a restricted reading of the saving clause. *Metropolitan Life*, 471 U.S. at 746.

[14] Further, while these comments were persuasive to this Court in the context of a law of general application, they are "of little help in analyzing § 514(b)(2)(A) for . . . the saving clause is broad on its face and specific in its reference." *Metropolitan Life*, 471 U.S. at 746 n.24.

[15] Bogan, *Protecting Patient Rights, supra*, at 956; *see also Pacific Gas & Elec. Co. v. State Energy Resources Conservation & Dev. Comm'n*, 461 U.S. 190, 204 (1983).

saving the entire field of state insurance regulation, for which ERISA provides no meaningful substitute.

It makes little sense for Congress to have supplanted an entire field of traditional state regulation and replace it with virtually nothing. Similarly, it makes little sense to have specifically saved state insurance laws and then strip the States of their ability to enforce their state laws by limiting the remedies only to those specifically drafted for the unrelated field of pension benefits. While petitioner repeatedly asserts that ERISA was intended to provide uniformity and that an expansive application of the saving clause would "swallow ERISA whole", Pet'r Br. at 36, this Court has already rejected such claims. "We recognize that applying the States' varying insurance regulations creates disuniformities for 'national plans that enter into local markets to purchase insurance.' [citation] As we have observed, however, '[s]uch disuniformities . . . are the inevitable result of the congressional decision to "save" local insurance regulation.' " *Ward*, 526 U.S. at 376 n.6.

Thus, the two reasons upon which this Court derived its exclusive remedy discussion in *Pilot Life* have no applicability to state insurance laws which are not only saved from preemption, but which Congress in the McCarran-Ferguson Act specifically mandated remain free of federal interference. The position set forth herein is precisely the view presented by the United States Solicitor General in *Ward*. *See* Br. of United States as *Amicus Curiae* in *Ward*, No. 97-1868 (filed November 1998) at 22-25.

C. ERISA's Legislative History Is Unequivocal In Disclosing That The Act Was Intended To Regulate Pension Benefits And Was Not Intended To Impact The Field Of Insurance.[16]

ERISA was the direct outgrowth of the explosion in private pension plans during the middle of the last century. The number of employees covered by such plans grew from approximately 4 million in 1940 to over 30 million by 1973.[17] The estimated assets held by such plans during this same period grew from $2.4 billion to $150 billion.[18] With this explosive growth came a similarly expansive growth in the abuses of such funds.[19] In

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[16] *See generally* Subcomm. on Labor of the Senate Comm. on Labor and Pub. Welfare, 94th Cong., Legislative History of the Employee Retirement Income Security Act of 1974 (Comm. Print 1976) [hereinafter "Legislative History"]; Special Comm. on Aging, U.S. Senate, 98th Cong., The Employment Retirement Income Security Act of 1974: The First Decade 1-25 (Comm. Print 1984) [hereinafter "The First Decade"].

The legislative history discussed herein is carefully and extensively set forth in greater detail in Bogan, *Protecting Patient Rights, supra*, 74 Tul. L. Rev. 951; *See also* David Gregory, *The Scope of ERISA Preemption of State Law: A Study in Effective Federalism*, 48 U. Pitt. L. Rev. 427, 437-457 (1987).

[17] *See* S. Rep. No. 93-127, at 3, *reprinted in* 1974 U.S.C.C.A.N. at 4839-40, and in 1 Legislative History, *supra* note 16, at 589.

[18] *See* H.R. Rep. No. 93-533, at 3, *reprinted in* 1974 U.S.C.C.A.N. at 4641, and in 2 Legislative History, *supra* note 16, at 2350; The First Decade, *supra* note 16, at 5; James D. Hutchinson & David M. Ifshin, *Federal Preemption of State Law Under the Employee Retirement Income Security Act of 1974*, 46 U. Chi. L. Rev. 23, 24 (1978).

[19] *See* 120 Cong. Rec. 29,934 (1974), *reprinted in* 3 Legislative History, *supra* note 16, at 4748 (remarks of Sen. Javits); The First Decade, *supra* note 16, at 6 n.22 (citing congressional hearings on abuse in pension plan administrations); *see also* David Gregory, *The Scope of ERISA Preemption of State Law: A Study in*

addition, the enormous accumulation of such funds exerted a major impact on the country's financial markets.[20] This explosion occurred without the benefit of any effective federal or state regulation.[21]

In 1954, at the request of President Eisenhower, Congress undertook an extensive study of the private pension industry.[22] This study disclosed abuses, including incompetent management of pension funds, looting, embezzlement, kickbacks, excessive administration costs and imprudent investment practices.[23] In response, Congress enacted the Welfare and Pension Plans Disclosure Act ("WPPDA") in 1958.[24] This law merely required the disclosure of certain financial information to the employees and did not provide any meaningful regulation of the funds themselves.[25]

This legislation was wholly ineffective.[26] Consequently, in 1962 President Kennedy appointed a special

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Effective Federalism, supra note 16, at 443-45 (referring to the many abuses in employee pension plans listed in ERISA's legislative history).

[20] *Id.*; H.R. Rep. No. 93-533, at 3, *reprinted in* 1974 U.S.C.C.A.N. at 4641, and in 2 Legislative History, *supra* note 16, at 2350.

[21] *See* note 17 *supra*.

[22] *See* S. Rep. No. 85-1440, at 2-11 (1958), *reprinted in* 1958 U.S.C.C.A.N. at 4137.

[23] *Id.* at 4137-47.

[24] Pub. L. No. 85-836, 72 Stat. 997 (1958) (repealed 1974).

[25] *See* H.R. Rep. No. 93-533, at 4, *reprinted in* 1974 U.S.C.C.A.N. at 4642, and in 2 Legislative History, *supra* note 16, at 2351; *Malone v. White Motor Corp.*, 435 U.S. 497, 507 (1978) (plurality opinion).

[26] *See* S. Rep. No. 93-127, at 4, *reprinted in* 1974 U.S.C.C.A.N. at 4841, and in 1 Legislative History, *supra* note 16, at 590; H.R. Rep. No. 93-533, at 4, *reprinted in* 1974 U.S.C.C.A.N. at 4642, and in 2 Legislative History, *supra* note 16, at 2351.

task force to study the problem.[27] The task force concluded that further federal regulation of private pension plans to include mandatory minimum vesting and funding requirements was necessary and that further study was required on other issues.[28] Significantly, the task force specifically did not investigate or consider any reforms of nonpension plans, such as health insurance plans.[29] In response to these concerns, New York Senator Jacob Javits introduced legislation in 1967 to create federal funding and participation requirements for private pension plans.[30] This lead to further Congressional

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[27] *See* President's Comm. on Corporate Pension Funds and Other Private Retirement and Welfare Programs, Public Policy and Private Pension Programs: A Report to the President on Private Employee Retirement Plans, at vii-viii (1965) [hereinafter "President's Committee Report"]; *see also* The First Decade, *supra* note 16, at 8-10 (describing the formation of the committee and its findings).

[28] *Id.*

[29] *See* President's Committee Report, *supra* note 27, at iv ("Although the area of investigation assigned to the Committee included welfare plans as well as retirement programs, the President's memorandum specifically raised questions about issues which arise primarily from retirement plans. Other types of welfare plans, such as health and insurance plans, make important contributions to the economic security of American workers; they do not, however, have the impact of pension plans on accumulation of savings, labor mobility, and similar matters touched upon by the President. Consequently, the Committee has confined its efforts to an inquiry into private employee retirement plans (i.e., excluding plans for self-employed persons) without any extensive study of other types of welfare plans.").

[30] *See* 113 Cong. Rec. 4650-53 (1967) (remarks of Sen. Javits); *see also* 120 Cong. Rec. 29,933-34 (1974), *reprinted in* 3 Legislative History, *supra* note 16, at 4748 (remarks of Sen. Javits) (recounting his continued efforts to reform the private pension and welfare system).

investigations and eventually ERISA. In 1970, the Subcommittee on Labor of the Senate Committee on Labor and Public Welfare began a three-year study "undertaken to ascertain the need for statutory protections for workers' pension programs and to formulate appropriate corrective legislation."[31]Like the previous investigations, the subcommittee's hearings disclosed a morass of abusive practices resulting in the loss of retirement benefits to employees as the result of inadequate funding, mismanagement and unreasonable vesting requirements.[32] It agreed with President Kennedy's task force and recommended comprehensive regulation of the pension industry.[33] Shortly thereafter, Senator Javits introduced Senate Bill 4. It stated, "[t]he purpose of S.4 is to prescribe legislative remedies for the various deficiencies existing in the private pension plan systems which have been determined by the Senate Subcommittee's comprehensive study of such plans."[34] A corresponding House bill was also introduced.[35]

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[31] *See* S. Rep. No. 92-634, at 1 (1972); *see also* 119 Cong. Rec. 30,003 (1973), *reprinted in* 2 Legislative History, *supra* note 16, at 1598 (statement of Sen. Williams).

[32] *See* H.R. Rep. No. 93-533, at 5-8 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4643-46, and in 2 Legislative History, *supra* note 16, at 2355.

[33] *See* 120 Cong. Rec. 29,935-44 (1974), *reprinted in* 3 Legislative History, *supra* note 16, at 4748 (remarks of Sen. Javits).

[34] S. 4, 93d Cong. (1973); *see* S. Rep. No. 93-127 (1973), at 1, *reprinted in* 1974 U.S.C.C.A.N. 4838, and in 1 Legislative History, *supra* note 16, at 587.

[35] *See* H.R. 2, 93d Cong. (1973), *reprinted in* 1 Legislative History, *supra* note 16, at 3.

These bills were sent to their appropriate committees, which issued their own reports. Each of these reports concerned themselves solely with abuses in, and the consequent need for, regulation of private pension plans.[36] The Senate Committee on Labor and Public Welfare report states:

> The provisions of S.4 are addressed to the issue of whether American working men and women shall receive private pension plan benefits which they have been led to believe would be theirs upon retirement from working lives. It responds by mandating protective measures and prescribing minimum standards for promised benefits. The purpose of S.4 is to prescribe legislative remedies for the various deficiencies existing in the private pension plan systems. . . .[37]

The report states that "[t]he principal issues affecting the vital and basic needs for legislative reform involve consideration of the essential elements of pensions: (1) "vesting," (2) "funding," (3) "reinsurance," (4) "portability" and (5) "fiduciary responsibility and disclosure."[38] Similarly, the House Committee on Education and Labor report states that the "primary purpose of the bill is the protection of individual pension rights" and

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[36] *See* S. Rep. No. 93-127, at 1-36, *reprinted in* 1974 U.S.C.C.A.N. at 4838-89, and in 1 Legislative History, *supra* note 16, at 587-622; H.R. Rep. No. 93-533, at 1-28, *reprinted in* 1974 U.S.C.C.A.N. at 4639-70, and in 2 Legislative History, *supra* note 16, at 2348-75; 120 Cong. Rec. 29,933-35 (1974), *reprinted in* 3 Legislative History, *supra* note 16, at 4746-51 (remarks of Sen. Javits).

[37] S. Rep. No. 93-127, at 1, *reprinted in* 1974 U.S.C.C.A.N. at 4844-77, and in 1 Legislative History, *supra* note 16, at 587.

[38] S. Rep. No. 93-127, at 8-11, *reprinted in* 1974 U.S.C.C.A.N. at 4844-77, and in 1 Legislative History, *supra* note 16, at 594-97 (emphasis omitted).

that the legislation was designed to: (1) establish minimum fiduciary standards for retirement plans, (2) provide for enforcement and public disclosure of finances, (3) improve the equitable character and soundness of private pension plans by requiring (a) appropriate vesting and (b) minimum funding standards, and (4) guarantee the adequacy of the plan's assets prior to termination.[39]

ERISA's legislative history is unequivocal that it was intended as a pension reform bill. In describing ERISA, Senator Javits said, "[T]he pension reform bill is the greatest development in the life of the American worker since social security. For the first time in our history most workers will be able to truly retire at retirement age and live decently on their social security and private pensions."[40] Senator Williams, Chairman of the Senate Committee on Labor and Public Welfare, described his committee's study which lead to ERISA. "This study clearly established that too many workers, rather than being able to retire in dignity and security after a lifetime of labor rendered on the promise of a future pension, find that their earned expectations are not to be realized."[41] In the House, one of the principal proponents, Representative Dent, described ERISA's purpose in this way: "[W]e started out with only one aim in view and that was to give a pension participant his entitlements under the

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[39] H.R. Rep. No. 93-533, at 1, 17-18, *reprinted in* 1974 U.S.C.C.A.N. at 4655-56, and in 2 Legislative History, *supra* note 16, at 2348, 2364-65.

[40] 3 Legislative History, *supra* note 16, at 4747 (remarks of Sen. Javits).

[41] 3 Legislative History, *supra* note 16, at 4733 (remarks of Sen. Williams).

contract of the pension plan he belonged to."[42] The record repeatedly references tragic examples of workers deprived of pension benefits after 30, 40 and 50 years of employment because they were a few days short of vesting before retiring, the company was sold or went bankrupt, or because the employer could not afford to pay the promised retirement benefits.[43]

While this Court has referred to ERISA as a "comprehensive and reticulated statute,"[44] it is so only with respect to pension plans, and the Court's description of the Act as such a statute originated in the context of pension cases.[45] The Act substantially regulated pension plans but contained virtually no meaningful regulation of insurers or insurance "plans."

What is clear from this long and extensive legislative history and the statute itself is that the exclusive concern of Congress in passing ERISA was to address abuses in the pension field. "ERISA was passed by Congress in 1974 to safeguard employees from the abuse and mismanagement of funds that had been accumulated to finance various types of employee benefits." *Massachusetts v. Morash*, 490 U.S. 107, 113 (1989). Not a single insurance concern is expressed anywhere in the legislative history.

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[42] 3 Legislative History, *supra* note 16, at 4665 (remarks of Rep. Dent).

[43] *See, e.g.*, 3 Legislative History *supra* note 16, at 4749-50 (remarks of Sen. Javits on "Why Pension Reform Is Needed"), (4791-96) (remarks of Sen. Bentson), (4664-65) (remarks of Rep. Thompson), (4710) (remarks of Rep. McClory); *Interim Report of Activities of the Private Welfare and Pension Plan Study, Subcommittee on Labor of the Committee on Labor and Public Welfare*, S. Rep. No. 92-634, 92d Cong., 2d Sess. (1972) at 67-90.

[44] *See, e.g., Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 510 (1981); *Nachman Corp. v. Pension Benefit Guar. Corp.*, 446 U.S. 359, 361 (1980).

[45] *Id.*

Instead, Congress expressly saved all insurance regulation to the States. This Court has endorsed this view, noting that the broad preemption clause was added at the last minute, that there is no legislative history discussing the relationship between the saving clause and the general preemption clause, and that there is a "complete absence of evidence" to support a narrow reading of the saving clause. *Metropolitan Life*, 471 U.S. at 745-46 n.21. As one commentator who has extensively reviewed ERISA's legislative history reports:

> . . . ERISA's legislative history is remarkable . . . for what it does not contain. ERISA's legislative history provides no evidence that Congress seriously investigated, studied, or debated any issues or concerns with nonpension employee benefit plans.
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> There is no documentation anywhere in ERISA's legislative history of any study or investigation of the history or growth of nonpension benefit plans, or of any specific concern with the management of nonpension plan assets. Further, ERISA's legislative history fails to disclose any concerted investigation of any complaints about nonpension benefits, such as inadequate health care, accident, death or disability coverage, or problems with health, life, or disability benefits claims. In short, Congress just was not dealing with nonpension benefit plans when it enacted ERISA.

Bogan, *Protecting Patient Rights*, *supra*, at 972, 976-77.

D. This Court Has Recognized That Remedial Laws Are At The Core Of The McCarran-Ferguson Act And Thus The Saving Clause.

This Court has repeatedly made clear that insurance enforcement mechanisms and laws regulating claims

practices are at the core of McCarran-Ferguson and thus ERISA's saving clause.

> Congress was concerned [in the McCarran-Ferguson Act] with the type of state regulation that centers around the contract of insurance. . . . The relationship between insurer and insured, the type of policy which could be issued, its reliability, its interpretation, *and enforcement* – these were the core of the "business of insurance." [T]he focus [of the statutory term] was on the relationship between the insurance company and the policyholder. Statutes aimed at protecting or regulating this relationship, directly or indirectly, are laws regulating the "business of insurance." *SEC v. National Securities, Inc.*, 393 U.S. 453, 460 (1969) (emphasis added).

Metropolitan Life, 471 U.S. at 744 (emphasis added). *Accord Ward*, 526 U.S. at 374 n.5 (stating that "laws regulating claims practices . . . [are included] in catalogue of state laws that regulate insurance.").

That state remedial statutes are squarely protected by McCarran-Ferguson was underscored again in *Humana*, 525 U.S. 299. Therein, insureds under certain health insurance contracts brought suit under RICO claiming that the insurers were secretly obtaining kickbacks from hospitals in violation of the health insurance agreements. The applicable Nevada state laws permitted the insured to sue the insurer in tort for violation of the covenant of good faith and fair dealing and for violation of the state's Unfair Insurance Practices Act. 525 U.S. at 312. The insurers sought to prevent the application of the federal RICO claim on the grounds that McCarran-Ferguson precluded the application of federal law in the face of these state-law remedies. This Court found that the RICO claim did not impair the state laws and therefore was not barred by McCarran-Ferguson.

Most significant is the fact that this Court less than three years ago specifically considered Nevada's state insurance remedies to be protected by McCarran-Ferguson. Indeed, the conclusion was apparently so obvious to this unanimous Court that its opinion reveals no inquiry or analysis as to whether the state insurance remedial laws were covered by McCarran-Ferguson.

Of even greater significance is that *Humana* appears to be directly at odds with *Pilot Life's* holding that the Mississippi insurance bad faith law at issue there was not within the scope of McCarran-Ferguson and thus ERISA's saving clause. Indeed, the Nevada insurance bad faith law appears to be indistinguishable from the Mississippi law at issue in *Pilot Life*. In *Pilot Life*, the Court concluded that the State bad faith law did not fall within the ambit of the McCarran-Ferguson Act. Yet, in *Humana*, the Court appears to have assumed it obvious that the identical Nevada law did.

Humana is significant for another reason. Petitioners claim that any law which provides a remedy other than those set forth in ERISA's Section 502 is necessarily in conflict with Section 502 and therefore preempted by principles of conflict preemption. Yet, under federal conflict analysis, preemption only occurs where it is impossible to comply with both state and federal law or where the state law stands as an obstacle to the accomplishments of the full purposes and objectives of Congress. *Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238, 248 (1984). Simply because a State may have an insurance remedy which may be either an alternative to the ERISA remedies or a supplement to them does not mean that it is either impossible to comply with both state and federal law or that the state law stands as an obstacle to the accomplishments of ERISA. As noted in *Humana*, Nevada has a "comprehensive administrative" scheme that prohibits various forms of insurance fraud and misrepresentations. RICO provides a different remedy. Nonetheless, the RICO

claims "complemented" the Nevada administrative regime and thus did not impair its laws. *Humana*, 525 U.S. at 313. The same can be said of the law in question here.[46] ERISA was intended to protect employee benefits. State insurance laws which further that goal, do not frustrate or impair ERISA. The fact that a remedy in addition to those set forth in ERISA is available to Moran enhances ERISA's basic purpose through an appropriate application of the saving clause.

E. ERISA's Enforcement Mechanisms Leave Insureds With No Effective Remedy And Do Not Conform With ERISA's Legislative History; Petitioner Is Not A Proper Party To An ERISA Action.

Strong evidence that ERISA was not intended to preempt state insurance enforcement actions is the fact that ERISA's remedies were drafted with pension plans in mind and are not suited to insurance claims. ERISA was intended to remedy abuses rampant in the administration of *funds*, which were held for the benefit of employees, *Morash*, 490 U.S. at 112-113, and thus ERISA only provides a remedy against the plan itself. In most insurance instances, however, there is no "fund," only a group insurance policy issued to an employer or employee organization insuring the employees, funded by premiums paid directly by the employer, employees or both to the

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[46] An insured may proceed to collect benefits pursuant to a Section 502 claim and seek additional appropriate relief by proceeding under a state law which is directed solely at the insurance industry, such as the Nevada bad faith claim or the claims referenced in note 3, *supra*. Rather than conflicting with ERISA, such state actions are entirely consistent with and complement ERISA's intent to protect employees by encouraging the prompt and fair payment of claims.

insurer.[47] The disputes in this context are fundamentally between the insured/employees and a third party, the insurer.

Strikingly, ERISA provides no effective remedy for an insured to obtain insurance benefits wrongfully denied. ERISA permits an insured to bring a civil action to recover benefits due. 29 U.S.C. § 1132(a)(1)(B). However, it does not permit a suit against the insurer, which owes the benefits. "ERISA permits suits to recover benefits only against the Plan as an entity." *Gelardi v. Pertec Computer Corp.*, 761 F.2d 1323, 1324 (9th Cir. 1985); *Garratt v. Knowles*, 245 F.3d 941, 949 (7th Cir. 2001). "An employee benefit plan may sue or be sued . . . as an entity." 29 U.S.C. § 1132(d)(1). "Any money judgment . . . against an employee benefit plan shall be enforceable *only against the plan* as an entity and shall not be enforceable against any other person. . . . " 29 U.S.C. § 1132(d)(2) (emphasis added).

Because of this, courts have repeatedly held insurers are not proper parties to an action under ERISA and have repeatedly dismissed actions filed against insurers. *See, e.g., Gibson v. Prudential Ins. Co. of N. Am.*, 915 F.2d 414, 417 (9th Cir. 1990); *Everhart v. Allmerica Financial Life Ins. Co.*, 1999 WL 498244 (N.D. Cal. 1999); *Roeder v. Chemrex, Inc.*, 863 F.Supp. 817, 828 (E.D. Wis. 1994); *Cohen v. Equitable Life Assurance Soc. of the United States*, 196 Cal.App.3d 669, 672-73 (1987).[48] This, coupled with the Court's holding in *Pilot Life*, has had the effect of granting insurers a

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[47] The exception is the instance of a self-funded plan, which is encompassed within ERISA and which is not typically regulated comprehensively by the States.

[48] Some courts have held, without statutory authority, that the administrator who controls the plan may be sued. *See, e.g., Garren v. John Hancock Mut. Life Ins. Co.*, 114 F.3d 186, 187 (11th Cir. 1997); *Rosen v. TRW, Inc.*, 979 F.2d 191, 193 (11th Cir. 1992). In any event, insurers generally are not administrators as defined by ERISA. 29 U.S.C. § 1002(16)(A)(i).

broad-based immunity, a result wholly unintended under ERISA. ERISA, a law enacted to protect employees, has thus been turned on its head to deny any meaningful relief against insurance industry abuses, a tragic result that numerous courts have decried.[49]

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[49] *See Bast v. Prudential Ins. Co.*, 150 F.3d 1003, 1005 (9th Cir. 1998) *cert. denied*, 120 S.Ct. 170 (1999) ("Although this case presents a tragic set of facts, the district court properly concluded that under existing law the Basts are left without a remedy"); *Cannon v. Group Health Serv. of Okla., Inc.*, 77 F.3d 1270, 1271 (10th Cir. 1996) ("Although moved by the tragic circumstances of this case and the seemingly needless loss of life that resulted, we conclude the law gives us no choice but to affirm [the grant of summary judgment to the insurer]"); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1338 (5th Cir. 1992) ("The result ERISA compels us to reach means the Corcorans have no remedy, state or federal, for what may have been a serious mistake"); *Andrews-Clarke v. Travelers Ins. Co.*, 984 F.Supp. 49, 52-53 (D. Mass. 1997) ("The tragic events set forth in Diane Andrews-Clarke's Complaint cry out for relief. . . . Under traditional notions of justice, the harms alleged . . . should entitle [her] to some legal remedy. . . . Nevertheless, this Court had no choice but to pluck [her] case out of the state court in which she sought redress (and where relief to other litigants is available) and then, at the behest of Travelers . . . , to slam the courthouse doors in her face and leave her without any remedy.") (footnotes omitted); *Florence Nightingale Nursing Serv., Inc. v. Blue Cross & Blue Shield*, 832 F.Supp. 1456, 1457 (N.D. Ala. 1993), *aff'd*, 41 F.3d 1476 (11th Cir. 1995); *Jordan v. Reliable Life Ins. Co.*, 694 F.Supp. 822, 827 (N.D. Ala. 1988); *see also* Bogan, *Protecting Patient Rights*, *supra* note 5, at 996-1002; Catherine L. Fisk, *The Last Article About the Language of ERISA Preemption? A Case Study of the Failure of Textualism*, 33 Harvard J. on Legis. 35, 38 (1996) ("It is a rich irony that ERISA, which was heralded at its enactment as significant federal protective legislation, has through its preemption provision been the basis for invalidating scores of progressive state laws.") (footnote omitted).

Thus, if Moran's state-law claim is preempted, petitioner is not a proper party to this ERISA action. While this result seems illogical, it is what ERISA would require. If Moran is precluded from asserting her state claim against petitioner, Moran's only permissible action under ERISA would be against her ERISA plan, not the insurer or HMO. It would be far more reasonable to believe that Congress intended to permit her to proceed against the insurer pursuant to the saved Illinois law than require her to proceed under Section 502 against the plan.

An action against a "plan" makes sense where the plan consists of a fund out of which benefits are paid, as in a pension plan or self-funded insurance, and it was these plans that concerned Congress when it passed ERISA. Yet, there is no such funded "plan" in existence with regard to insurance policies. In fact, the "plan" in many instances does not really exist at all, but is a fictional entity created under ERISA. Indeed, the "plan" often is nothing more than a group insurance policy issued to an employer and insuring the employees.[50] The "plan" itself has no bank account, no assets, no address, no office, no employees and no trustees. And while there are a few regulations applying to such plans, in many instances these regulations merely require financial reporting, which is meaningless in the case of an insurance plan, and there is often no one to comply with these regulations.[51]

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[50] *See, e.g., Gaylor v. John Hancock Mutual Life Ins. Co.*, 112 F.3d 460, 463-65 (10th Cir. 1970); *Butero v. Royal Maccabees Life Ins. Co.*, 174 F.3d 1207 1213-15 (11th Cir. 1999); *Marshall v. Bankers Life & Cas. Co.*, 2 Cal. 4th 1045, 1054, 832 P.2d 573 (1992).

[51] Indeed, the department of labor regulations do not even require such reporting if the plan has fewer than 100 participants. 29 C.F.R. §§ 2520.104-20, 2520.104-21. Moreover, even if all of the regulations are ignored, a plan will be deemed to exist anyway. *See Blau v. Del Monte Corp.*, 748 F.2d 1348, 1352 (9th Cir. 1984).

Further, the statutory history of the preemption clause itself confirms that ERISA was intended to apply to funds and not to comprehensively regulate private insurance arrangements. As noted above, the preemption clause was significantly broadened during the House/Senate conference committee. Yet, while simultaneously broadening the preemption clause, it also included the deemer clause,[52] which preserved ERISA's preemption for self-funded plans.[53] In light of the saving clause, this created a clear distinction in ERISA's impact on self-funded insurance arrangements as opposed to private insurance arrangements.[54] The former were swept into ERISA's broad preemption provision, the latter were specifically excluded.

United Policyholders respectfully submits that many of the problems arising out of ERISA insurance claims stem from this Court's decision in *Pilot Life*. United Policyholders submits that the Court should re-examine its holding in *Pilot Life*. In light of (1) ERISA's clear purpose to regulate pension and not insurance difficulties, (2) the saving clause, which saves "any" laws regulating insurance and (3) the complete unsuitability of ERISA's remedies to insurance claims, we believe Congress intended to save from preemption *all* state laws which would have the effect of regulating the conduct of insurers. This would include such basic claims as breach of contract, fraud and certainly insurance bad faith, to the extent they are exercised to enforce claims against insurers or to define impermissible conduct by insurers. United Policyholders submits that Congress never intended to deprive an insured of her basic right to sue

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[52] 29 U.S.C. § 1144(b)(2)(B).

[53] H.R. Rep. No. 93-1280, 93rd Cong. 2d Sess. at 383, *reprinted in* 3 Legislative History, *supra* note 16, at 4650.

[54] *See Metropolitan Life*, 471 U.S. 724, 747.

an insurer for breach of contact, to deprive her of her basic right of a jury trial, and to preclude the insured from pursuing the basic right to sue the insurer for benefits wrongfully denied, only to replace it with a remedy which effectively permits an insurer to deny a claim as long as it does not do so in an arbitrary and capricious fashion. It is hard to imagine why Congress would have intended (but not stated in the statute) that traditional state insurance remedies forged by the States to address the specific issues of insurance enforcement be replaced with remedies completely unsuitable to the resolution of insurance disputes.[55] It is a particularly difficult leap of faith in light of the complete absence of legislative history to support such a conclusion and the explicit terms to the contrary of the saving clause itself.

At the end of his dissent in the Seventh Circuit opinion, Justice Posner writes of the inconsistency of the majority opinion. He argues that a law cannot be both written into an insurance contract and an ERISA plan. The answer, however, is not to preempt the Illinois law, but to apply the saving clause and permit the state-law claim to survive on its own.

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[55] An example can serve to illustrate the absurdity of the ERISA remedy. Suppose an individual becomes disabled while insured under a group disability policy issued to his employer and within the scope of ERISA. The evidence of the disability "plan" is the group policy itself and perhaps the booklet explaining coverage delivered to him by his employer. Benefits are paid and shortly thereafter the employer goes out of business. Five years later the insurer wrongfully terminates benefits. The insured would have to file suit against the "long term disability plan" (a non-existent entity) of a non-existent employer. No action would lie against the insurer, which owes the benefits.

II. THE TRIAL COURT LACKED SUBJECT MATTER JURISDICTION.

This action was originally filed in the State court of Illinois and removed to federal court. The Court of Appeals found jurisdiction to be proper, concluding that Moran's claim should properly be considered as one arising under Section 502 and that Section 4-10 of the Illinois law should be applied in the context of a claim for ERISA benefits. As such, the Court found that she had no separate state claims and thus, the doctrine of complete preemption permitted removal.

United Policyholders submits this was incorrect. Moran's claim against petitioner was not preempted. She was entitled to proceed under state law directly against petitioner. Because her claims are not completely preempted, the well-pleaded complaint rule precludes removal, notwithstanding petitioner's claim of a federal defense. *Franchise Tax Bd.*, 463 U.S. at 10-11.

CONCLUSION

ERISA's statutory history as pension reform legislation is unequivocal. Its language saving any state law regulating insurance is unambiguous and, because ERISA was not intended to regulate insurance, it fails to provide a meaningful remedy to resolve insurance disputes. Under this Court's long-established principles of statutory construction, Moran's claim should be returned to the Illinois State court, where she may pursue her Section 4-10 claim against petitioner directly.

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No. 00-1021

In the Supreme Court of the United States

RUSH PRUDENTIAL HMO, INC.,
Petitioner,

v.

DEBRA C. MORAN AND STATE OF ILLINOIS,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

BRIEF OF THE STATES OF TEXAS, ARIZONA, CALIFORNIA, CONNECTICUT, DELAWARE, FLORIDA, HAWAII, INDIANA, MAINE, MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA, MISSISSIPPI, MISSOURI, MONTANA, NEVADA, NEW JERSEY, NEW MEXICO, NEW YORK, NORTH CAROLINA, OHIO, OKLAHOMA, PENNSYLVANIA, SOUTH CAROLINA, TENNESSEE, UTAH, VERMONT, VIRGINIA, WASHINGTON, WEST VIRGINIA, AND WYOMING, AND THE TERRITORY OF PUERTO RICO AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS

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QUESTION PRESENTED

Whether Congress intended that the Employee Retirement Income Security Act of 1974 (ERISA) preempt state laws that provide for binding, independent review of an HMO's decision that the treatment recommended by a patient's treating physician is not medically necessary.

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INTEREST OF THE *AMICI CURIAE*

The state *amici curiae*, through their Attorneys General, respectfully submit this brief in support of Respondents Moran and State of Illinois asking the Court to affirm the judgment of the Seventh Circuit. States have a vital interest in ensuring that the scope of preemption by the Employee Retirement Income Security Act of 1974 (ERISA) is not extended beyond Congress's intent. The text of ERISA and decisions of this Court evidence that Congress intended to reserve powers to the States. ERISA § 514(b)(2)(A) preserves the States's authority to regulate insurance and nothing in ERISA evidences an intent to displace the States's historical role to regulate healthcare. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. 645, 661 (1995).

The statute at issue in this case, § 4-10 of the Illinois HMO Act is one of forty state independent review statutes[1]

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[1] 215 ILL. COMP. STAT. 125/4-10; ALASKA STAT. § 21.07.050; ARIZ. REV. STAT. § 20-2537; CAL. [HEALTH & SAFETY] CODE § 1374.30; CAL. [INS.] CODE § 10169; COLO. REV. STAT. § 10-16-113.5; CONN. GEN. STAT. § 38a-478n; DEL.CODE tit. 16, § 9119; FL. STAT. §§ 641.51–641.511; GA. CODE § 33-20A-32; HI. REV. STAT. § 432E-6; IND. INS. CODE § 27-13-10.1-1; IOWA CODE § 514J; KAN. STAT. § 40-22a13; KY. ST. § 304.17A-623; LA. REV. STAT. § 22:3081; ME. REV. STAT. tit. 24-A § 4312; MD. CODE [INS.] § 15-10A-03; MASS. GEN LAWS ch. 1760, § 14; MICH. COMP. LAWS §§ 550.1901–1929; MINN. STAT. § 62Q.73; MO. REV. STAT. § 376.1385; MONT. CODE § 33-37-102; N.H. REV. STAT. 420-J:5; N.J. STAT. §§ 26:2S-11, 26:2S-12; N.M. ADM. CODE tit. 13, § 10.17.24; N.Y. [INS.] LAW § 4910; N.Y. [PUB. HEALTH] LAW § 4910; 2001 N.C. Sess. Laws 446 (S.B. 199); OHIO REV. CODE § 1751.84; OKLA. STAT. tit. 63, § 2528.3; OR. LEGIS. ch. 266; 40 PA. STAT. §

that provide some form of independent review of a health maintenance organization's (HMO) reversal of a treating physician's medical-necessity decision. These statutes are intended to improve the quality of care provided by HMOs.[2] Although the particulars of independent review differ from State to State, the laws all require an HMO to use an independent reviewer. *External Revire Update*, p.1. Differences among the States include the role of regulatory agencies, and whether the insured, the physician, or another individual may request the independent review. *Id.* But they all "serve as a safety valve" to correct mistakes or ill-advised decisions by HMOs. *Id.* This is all part of the States's traditional function of regulating healthcare and insurance. Rush Prudential's claim of a right to engage in medical decisionmaking without regard for state law cannot be squared with congressional intent, this Court's jurisprudence, and federalism concerns. The state *amici curiae* ask the Court to affirm the Seventh Circuit's judgment, which held that § 4-10 of the Illinois HMO Act is not preempted by ERISA.

991.2162; R.I. GEN. LAWS § 23-17.12-10; S.C. CODE §§ 38-71-1910–2060; TENN. CODE § 56-32-227; TEX. INS. CODE art. 21.58A; UTAH CODE § 31A-22-629; VT. STAT. tit. 8, § 4089f; VA. CODE §§ 38.2-5900–5905; WASH. REV. CODE § 48.43.535; 2001 W. Va. Acts 166 (H.B. 2216) (to be codified at W. VA. CODE § 33-25C-6). The District of Columbia also has enacted an independent review statute. D.C. CODE § 32-571.7.

[2] Geraldine Dallek and Karen Pollitz, Institute for Health Care Research and Policy, Georgetown University, *External Review of Health Plan Decisions: An Update*, May 2000, p.1, <http://www.kff.org/content/archive/3020/review_r.pdf> (prepared for the Henry J. Kaiser Family Foundation) ("*External Review Update*").

SUMMARY OF ARGUMENT

The circuit courts have often taken such an expansive view of ERISA's "relate to" preemption clause that "for all practical purposes pre-emption would never run its course." *Travelers*, 514 U.S. at 655. Consequently, this Court ruled that absent the express intent of Congress to preempt, traditional state powers can and should coexist with federal regulation. *Id.* at 661. Again, in 1997, the Court applied traditional preemption analysis, rather than relying on the enigma of ERISA's express preemption clause, to determine whether ERISA preempted state law. *Boggs v. Boggs*, 520 U.S. 833 (1997). The circuits, however, continue to employ myriad "relate to" tests and, as a result, ERISA preemption analysis is mired in a jurisprudential quagmire. This Court should clarify that ERISA's express preemption provision, including the "relate to" clause, is essentially a reference to traditional preemption jurisprudence.

Under traditional preemption principles, as well as the test for ERISA preemption enunciated in cases such as *California Division of Labor Standards Enforcement v. Dillingham Construction, N.A., Inc.*, 519 U.S. 316 (1997), independent review statutes, like § 4-10, are not preempted by ERISA. This Court noted in *Pegram v. Herdrich*, 530 U.S. 211 (2000), that medical-necessity decisions are mixed-eligibility decisions consisting of aspects of both medicine and coverage, but reserved the question of what standards would govern a claim by a patient who was denied reimbursement for medical care. *Pegram*, 520 U.S. at 229 n.9 (citing 29 U.S.C. § 1132(a)(1)(B)). This case places that unresolved question squarely before this Court.

In order to answer that question, the Court must first determine whether the coverage aspect of a mixed-eligibility decision predominates over the medical aspect. The state *amici* believe the medical aspect must necessarily predominate in a medical-necessity decision, as the very terms imply. The question is one of medical necessity—a decision involving the exercise of medical judgment. Because regulation of the exercise of medical judgment is historically a matter of State concern, there must be some evidence that Congress intended to preempt the States's ability to regulate these decisions. The state *amici* maintain that there is no evidence of such congressional intent and thus independent review laws—the process the States have chosen to regulate these medical-necessity decisions—are not preempted by ERISA.

Even if, on the other hand, the Court concludes the coverage aspect of a medical-necessity decision predominates, then independent review laws are nevertheless not preempted for two reasons. First, independent review laws do not impinge on plan administration in a way that requires preemption because medical-necessity decisions are necessarily unique, fact-specific decisions involving medical judgment, rather than uniform coverage decisions involving interpretation of plan documents. Second, if medical-necessity decisions are construed as coverage decisions, then they should be considered insurance coverage decisions, and Congress expressly partitioned the power to regulate insurance from ERISA's preemptive reach. Although the regulation of mixed-eligibility decisions may not appear to be traditional insurance regulation, that is because of the medical nature of the decisions. If the decisions do not fall under the purview of medical regulation because of the coverage aspect

of the decision, that cannot mean the coverage aspect is not under the purview of insurance regulation because of the medical aspect of the decision. To hold otherwise allows HMOs to evade state regulation entirely by couching their coverage decisions in terms of medical necessity. The state *amici* believe there is no evidence that Congress intended to grant HMOs this unique exemption from all state regulation.

Although Rush Prudential asserts that Illinois's independent review law is preempted as an alternate enforcement mechanism that conflicts with ERISA § 502(a), an analysis of this Court's decisions construing § 502(a) demonstrates that Congress did not intend for § 502(a) to preempt state independent review laws. If medical-necessity decisions are viewed as medical in nature and Congress did not intend for ERISA's express preemption provision to preempt state healthcare regulation, it could not have intended for § 502(a) nevertheless to preempt that very same state regulation. If these decisions are considered only coverage decisions involving payment, then independent review laws would come within ERISA's saving clause, and § 502(a) should not be construed contrary to the express language of the saving clause to preempt state insurance laws.

Finally, in any event, the concerns underlying this Court's decisions that § 502(a) preempts alternate enforcement mechanisms are not at issue in medical-necessity decisions because the very nature of these decisions involve questions of medical judgment, not plan interpretation. The questions raised are not whether a plan has chosen to cover a particular treatment. The questions are whether a covered treatment is medically necessary. These are fact-specific

questions as this Court noted in *Pegram*. Even though those fact-specific questions may be the basis of both an independent review and a § 502(a) action, that does not give rise to preemption under this Court's decision in *Lingle v. Norge Division of Magic Chef, Inc.*, 486 U.S. 133 (1988), a case underpinning this Court's alternate enforcement mechanism preemption decisions.

ARGUMENT

The Seventh Circuit held that ERISA did not preempt § 4-10 of the Illinois HMO Act. *Moran v. Rush Prudential HMO, Inc.*, 230 F.3d 959 (7th Cir. 2000). The court thought that § 4-10 could subject ERISA plans to conflicting state regulations and, therefore, had a "connection with" ERISA. *Id.* at 968. But the court held that § 4-10, as a law regulating insurance, becomes part of the insurance contract. *Id.* at 970. Additionally, because § 4-10 could only be enforced in an ERISA § 502(a) proceeding, the court held that there was no conflict. *Id.* This analysis is consistent with this Court's prior decisions, but the state *amici* think there are distinct and more fundamental reasons why § 4-10 is not preempted.

I. This Court Should Clarify that Traditional Preemption Principles Govern ERISA Preemption Analysis.

Whether ERISA preempts § 4-10 of the Illinois HMO Act necessarily involves the text of § 514 of ERISA and its "relate to" clause. 29 U.S.C. § 1144(a). Because this clause lacks any discernable content, "ERISA preemption of state law has left courts, including the Supreme Court, deeply troubled." *Prudential Ins. Co. of Am. v. Nat'l Park Med.*

Ctr., 154 F.3d 812, 815 (8th Cir. 1998). A federal judge has opined that "the words 'relate to' stretch and contract like a rubber band" as courts wrestle with the inequities of ERISA preemption. William M. Acker, Jr., *Can the Courts Rescue ERISA?*, 29 CUMB. L. REV. 285, 289 (1999). But in 1993, the Court held that "we discern no solid basis for believing that Congress, when it designed ERISA, intended to fundamentally alter traditional preemption analysis." *John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86, 99 (1993). This Court should clarify that the "relate to" provision in ERISA is not a unique species of preemption peculiar to ERISA, but should be interpreted in accordance with traditional preemption principles.

Nearly six years ago, the Court held that "relate to" preemption analysis must go beyond ERISA's unhelpful text and look to "the objectives of the ERISA statute as a guide." *Travelers*, 514 U.S. at 656. This Court admonished the lower courts for interpreting ERISA § 514(a) with an "uncritical literalism" that only results in "infinite connections" that Congress did not intend. *Id.* Nevertheless, the confusion persists in the lower courts and the threat remains that the "relate to" clause will be incorrectly applied to displace state regulations Congress never intended to preempt.

Last term, Justice Scalia cautioned that the only way to give this statute a "plausible and precise content" that "would not pick up every ripple in the pond" is to interpret ERISA's "relate to" clause "as a reference to our ordinary pre-emption jurisprudence." *Egelhoff v. Egelhoff*, 121 S.Ct. 1322, 1331 (2001) (Scalia, J., concurring); *see also Dillingham*, 519 U.S. at 336 (1997) (Scalia, J., concurring).

Likewise, Justice Breyer wrote that "[l]ike Justice Scalia, I believe that we should apply normal conflict pre-emption and field pre-emption principles where, as here, a state statute covers ERISA and non-ERISA documents alike." *Egelhoff*, 121 S.Ct. at 1331 (Breyer, J., dissenting). Employing traditional preemption analysis to § 4-10 of the Illinois HMO Act would clarify this Court's past holdings and offer the lower courts much needed guidance.

This Court's past holdings examining ERISA's express preemption provision can be reconciled with traditional preemption analysis. The "relate to" clause has been construed as a two-part test, which asks whether the law: (i) expressly "refers to" or acts exclusively on ERISA plans; or (ii) has an impermissible "connection with" ERISA. *Dillingham*, 519 U.S. at 324–25. The state *amici* suggest that the "connection with" analysis be considered field preemption analysis encompassing "whether the state law intrudes into an area Congress—given ERISA's basic objectives—would have wanted to reserve exclusively for federal legislation." *Boggs*, 520 U.S. at 860 (Breyer, J., dissenting).

The areas Congress wanted to reserve exclusively for federal regulation are an employer's decision to provide benefits and a multistate employer's ability to administer and to pay for those benefits in a uniform fashion.[3] Accordingly,

[3] State laws that are dependent on the existence of an ERISA plan for an element of the state-law cause of action or expressly refer to ERISA plans can also be said to fall within the field Congress intended to preempt. *See District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125 (1992); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990); *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1988).

this Court has held that state mandated benefit laws are preempted. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985); *Shaw v. Delta Air Lines*, 463 U.S. 85, 97 (1983). In both *Shaw* and *Metropolitan Life*, however, the Court held that specific provisions in ERISA saved the state laws, *i.e.*, removed them from the field of preemption. *Shaw*, 463 U.S. at 108; *Metropolitan Life*, 471 U.S. at 746-47. The Court has also held that States cannot require multistate plans to calculate benefits in different ways.[4]

The concept of uniformity of benefits and plan administration is only relevant to multistate ERISA plans. An ERISA plan operating only within one State cannot, by definition, be subject to different state laws.[5] Also, many ERISA plans purchase insurance or use third parties to administer their self-funded plans. The fact that these insurers and third-party administrators may operate nationally and offer the same benefits and administration in different States is not,

[4] *See FMC Corp. v. Holliday*, 490 U.S. 52, 60 (1990) (Pennsylvania law could not be enforced against self-funded plans because "[i]t requires plan providers to calculate benefit levels in Pennsylvania based on expected liability conditions that differ from those in States that have not enacted similar anti-subrogation legislation."); *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 14 (1987) (Maine's severance pay law was not preempted because requiring a one-time payment of a benefit did not create the potential for conflicting regulation of benefit plans); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 524 (1981) (New Jersey law preempted by ERISA "because it eliminates one method for calculating pension benefit—integration—that is permitted by federal law").

[5] The record does not reflect whether the employer in this case was a multistate employer with a multistate ERISA plan.

however, of any consequence. As this Court recognized in *Coyne*, "ERISA's preemption provision does not refer to state laws relating to 'employee benefits,' but to state laws relating to 'employee benefit plans.'" 482 U.S. at 7. Accordingly, state laws regulating intrastate ERISA plans do not effect plan uniformity. Moreover, uniformity is only an issue in a multistate plan where the procedure effected by the state law is uniform in nature, such as a method for calculating benefits. If the plan procedure by its nature does not produce uniform results, Congress's concern with uniformity is not implicated.

Plan uniformity is also the basis of this Court's finding that state laws that provide alternate enforcement mechanisms are preempted by ERISA § 514(a). *Travelers*, 514 U.S. at 658 ("we have held that state laws providing alternate enforcement mechanisms also relate to ERISA plans, triggering preemption" (citing *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990))). In *Ingersoll-Rand*, the Court held that a wrongful discharge action under Texas law for terminating an employee to avoid paying benefits was preempted because ERISA § 510 provided an identical claim that could be enforced under § 502(a). The Court explained that the state action related to an ERISA plan because state courts might develop different substantive standards applicable to wrongful discharge actions and "[s]uch an outcome is fundamentally at odds with the goal of uniformity that Congress sought to implement." 498 U.S. at 142.

Even where state laws are construed as effecting plan administration and uniformity, however, that is not the end of the inquiry. As this Court recognized, a state law that effects plan administration only because it increases costs to the plan

is insufficient to result in preemption.[6] If any law that effected plan administration was preempted, then ERISA preemption would be just as expansive as an unfettered "relate to" analysis—an analysis rejected by this Court in *Travelers*. Moreover, in areas of traditional state regulation, there must be more than simply an impact on plan administration, there must be some evidence that Congress intended to place such state laws within ERISA's preemptive reach.

When a party challenges an exercise of the States's historic police powers, then that party "bear[s] the considerable burden of overcoming 'the starting presumption that Congress does not intend to supplant state law.'" *De Buono*, 520 U.S. at 814 (citing *Travelers*, 514 U.S. at 654; *Dillingham*, 519 U.S. at 325). This reluctance to find preemption applies "with equal force where Congress has spoken, though ambiguously." *Cipollone v. Liggett Group, Inc.*, 505 U.S. 504, 533 (1992) (Blackmun, J., concurring). Healthcare regulation is an exercise of police power traditionally left to state regulation. *Travelers*, 514 U.S. at 654-55. *See also Pegram*, 530 U.S. at 237 and *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 475 (1996) (holding that healthcare regulation is a traditionally reserved state power).

Independent review laws, depending on how the Court interprets a mixed-eligibility decision, involve either healthcare

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[6] *De Buono v. NYSA-ILA Medical & Clinical Services Fund*, 520 U.S. 806, 816 (1997) ("Any state law, or other law, that increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is pre-empted by the federal statute.").

or insurance—both traditional areas of state regulation. Therefore, state independent review laws are presumptively not preempted absent evidence of legislative intent that preemption was the "clear and manifest purpose" of Congress. *Travelers*, 514 U.S. at 654. ERISA preemption analysis in this case must begin and end with that premise.

II. Section 4-10 is Not Within the Field of ERISA's Express Preemption Provision and Is Within the Scope of the State Laws That Congress Understood Would Survive ERISA Preemption.

Section 4-10 addresses healthcare issues outside the field of ERISA preemption. Moreover, even if § 514(a) "connection with" analysis is given a discrete meaning, § 4-10 would likewise survive ERISA preemption because independent review laws are within "the scope of the state law that Congress understood would survive" and the "nature and effect" of independent review laws do not require preemption.[7] As this Court noted in *Pegram*, utilization review contains a medical component. 530 U.S. at 229 (a medical-necessity decision "cannot be untangled from physicians' judgments about reasonable medical treatment"). It is this medical component that the States seek to regulate.

State independent review statutes review the medical judgment exercised in a mixed-eligibility decision. The purpose of these statutes is to decide whether the HMO correctly determined the "appropriate medical response" to a

[7] *See Egelhoff*, 121 S.Ct. at 1327 (quoting *Dillingham*, 519 U.S. at 325 and *Travelers*, 514 U.S. at 656).

given "patient's constellation of symptoms." *Pegram*, 530 U.S. at 228. The issue is what medical response a patient's condition necessitates. Even though treatment and coverage become inextricably mixed because of the nature of managed care, that does not change the medical nature of the decision.

Independent review statutes address the central issue of healthcare regulation—is medical treatment necessary? If Congress did not intend to impose ERISA fiduciary obligations on HMOs for medical-necessity decisions, *see Pegram*, 530 U.S. at 231, then there is no reason to think, nor is there any legislative history to show, that Congress nevertheless intended ERISA to preempt the States's regulation of medical-necessity decisions. Although not explicitly decided in *Pegram*, the Court's analysis in *Pegram* indicates that a mixed-eligibility decision made by a treating physician is not within the field of ERISA preemption. The question then arises, are mixed-eligibility decisions made by an HMO within the field of ERISA preemption?

When a medical director of an HMO makes a mixed-eligibility decision, can a state discipline that physician when the exercise of that medical judgment does not comply with the state standard of medical care? The state *amici* believe the answer is yes, as does the Missouri Supreme Court,[8] because

[8] "The determinations at issue in this case fall outside the scope of plan administration. Dr. Fallon did not simply look to a predetermined list of covered procedures to arrive at his conclusions. He used medical training and judgment to make a decision about the 'medical necessity' of surgical treatment for a particular patient. This medical judgment is analytically distinct from the coverage policies adopted by the employee benefit plan. Though the choice to cover a patient's expenses is an administrative

the only issue being addressed is whether the appropriate medical standards were used. Although the review of a medical-necessity decision by a medical review board can be distinguished from the independent review of that decision, at their heart, both involve a review of the medical judgment exercised by a physician—a role historically left to the States.

HMOs may claim that there is a distinction between a treating physician making a mixed-eligibility decision and an HMO making a mixed-eligibility decision, but that is a distinction without a practical difference, at least with respect to review of prospective and concurrent mixed-eligibility decisions. Whether it is the treating physician or the HMO deciding that treatment is not medically necessary, the result is the same. The patient will likely not receive medical care. J. Scott Andresen, *Is Utilization Review the Practice of Medicine?, Implications for Managed Care Administrators*, 19 J. LEGAL MED. 431, 434 (Sept. 1998).

While it is true that this case involves retrospective review for reimbursement, not concurrent or prospective review effecting patient care,[9] that does not render the medical

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choice, a physician's finding of 'medical necessity is purely a medical decision. . . . Whether such medical judgment is exercised by a physician providing direct treatment or by a physician during utilization review is merely coincidental to the Board's review power." *State Bd. for the Healing Arts v. Fallon*, 41 S.W.3d 474, 477 (Mo. 2001), *cert. denied*, 70 U.S.L.W. 3129 (U.S.Mo. Oct. 29, 2001)(No. 01-241).

[9] Illinois's statute provides retrospective review for denial of payment based on the medical necessity of a physician's treatment decision. Other States, such as Texas, have enacted statutes that only provide prospective

component of a mixed-eligibility decision any less a question of the exercise of medical judgment. That in this case Illinois chose to regulate the exercise of that medical judgment through an independent review should not strip Illinois of its authority merely because a plan chose to define coverage in medical terms. There is no evidence that Congress intended this and state regulation of medical-necessity decisions should thus be considered outside the scope of ERISA preemption.

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or concurrent review. *See, e.g.*, TEX. INS. CODE art. 21.58A. Indeed, Texas's petition for review is still pending before this Court. *See Corp. Health Ins., Inc. v. Tex. Dep't of Ins.*, 215 F.3d 526, *reh'g en banc denied*, 220 F.3d 641 (5th Cir. 2000), *petition for cert. filed sub nom Montemayor v. Corporate Health Ins., Inc.*, 69 U.S.L.W. 3317 (U.S. Oct. 24, 2001) (No. 00-665). In *Corporate Health*, Texas seeks reversal of the Fifth Circuit's judgment, which held that Texas's independent review statute is preempted by ERISA. If the Court affirms the Seventh Circuit's judgment in *Moran*, it should grant Texas's petition for certiorari in *Corporate Health* and reverse the Fifth Circuit's judgment, since the Fifth Circuit's ERISA preemption analysis conflicts with *Moran*. *See Moran*, 230 F.3d at 973 (Posner, J. dissenting) (noting the "square conflict"). At a minimum, the Court should grant Texas's petition, vacate the Fifth Circuit's judgment, and remand for reconsideration in light of this Court' s decision in *Moran*.

Moreover, the Court should grant Texas's petition even if it reverses *Moran*, because Texas's statute can survive ERISA preemption even if the Court determines that Illinois's statute cannot. The state *amici* believe that neither statute is preempted by ERISA, but if the Court disagrees as to the Illinois provision at issue in *Moran*, that holding would not necessarily apply to other state independent review provisions—like Texas's—that provide for only prospective or concurrent review. That distinct issue can be squarely resolved by granting Texas's petition for review in *Corporate Health*.

Moreover, HMO complaints that independent review laws interfere with plan administration are overwrought. An ERISA plan is free to include any benefits or exclude any benefits it desires. Section 4-10 only operates once a plan has determined what benefits it will provide and then only when a plan defines its payment obligations in medical terms.

Rush Prudential also heralds uniformity as a reason for allowing it to avoid state regulation of its medical-necessity decisions and such purported uniformity is the basis for claiming § 4-10 relates to an ERISA plan as an alternate enforcement mechanism. *See Ingersoll-Rand*, 498 U.S. at 142. But every medical-necessity decision is, by definition, devoid of uniformity since it is particular to the patient whose health is at issue. As this Court has recognized:

> [a]lthough coverage for many conditions will be clear and various treatment options will be indisputably compensable, physicians still must decide what to do in *particular* cases. The issue may be, say, whether one treatment option is so superior to another *under the circumstances*, and needed so promptly, that a decision to proceed with it would meet the medical necessity requirement that conditions the HMO's obligation to provide or pay for that *particular* procedure at that time.

Pegram, 530 U.S. at 228–29 (emphasis added).

While at first blush retrospective independent review laws appear to govern the payment of benefits, that is incidental to the review of the exercise of medical judgment inherent when a plan conditions payment for coverage in terms

of medical necessity. Unlike a situation in which a state law dictates who a beneficiary is, or requires payment contrary to the terms of plan documents,[10] independent review laws review an HMO's exercise of medical judgment, not an HMO's interpretation of plan documents. Every time an HMO determines whether a physician's recommended treatment is medically necessary, it is making a unique decision based on the specific symptoms of a specific patient. These decisions, by definition, are made on a case-by-case basis, not by reference to plan documents, but by reference to the beneficiary's medical condition. Rush Prudential's argument that Illinois's independent review law is preempted because it interferes with plan administration is, therefore, inapposite in the medical-necessity context, because medical judgment, not plan interpretation, is in question and "uniformity" is a practical impossibility.

III. Congress Expressly Intended State Insurance Laws, Like § 4-10, to Survive Preemption Analysis.

If mixed-eligibility decisions, despite the fundamental medical nature of the decisions, are considered coverage decisions, then laws regulating the making of these coverage decisions by HMOs should be considered insurance laws expressly saved from preemption. Indeed, because of the mixed nature of the decisions, it is conceivable that a mixed-eligibility decision can be construed as both an exercise of medical judgment that implicates state healthcare regulation

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[10] *See, Egelhoff*, 121 S.Ct. at 1327 ("the administrators must pay benefits to the beneficiaries chosen by state law, rather than those identified in plan documents.")

and a coverage issue of payment that implicates traditional insurance regulation. Although the Fifth Circuit differed from the Seventh Circuit on the whether ERISA § 502(a) requires preemption of independent review laws, both circuit courts had no difficulty concluding that independent review laws were laws regulating insurance within the ambit of ERISA's saving clause because they met the common-sense definition of insurance and at least two of the three McCarran-Ferguson Act factors. *Moran*, 230 F.3d at 969; *Corporate Health*, 215 F.3d at 538.

The Fifth Circuit's reasoning that independent review laws are laws regulating insurance is telling:

> Independent review provisions create a regulatory scheme governing health benefit determinations. They do not rely on general legal rights used in other areas of law. That the provisions apply to managed care entities as well as to traditional insurers does not exclude them from the saving clause. . . . In making benefit determinations, these entities are functioning as insurers.

Corporate Health, 215 F.3d at 538 (internal citations omitted). Independent review laws also "go to the core of the insured-insurer relationship" because they "create a procedural right of the insured against the entity" and accordingly "they meet the common sense test of the saving clause." *Id.*; *accord Moran*, 230 F.3d at 969-70. "For the same reasons, the provisions satisfy the second and third prongs of the McCarran-Ferguson test: they are integral to the policy relationship and regulate the insurance industry." *Corporate Health*, 215 F.3d at 538. Accordingly, "Section 4-10 clearly

satisfies the second and third McCarran-Ferguson factors." *Moran*, 230 F.3d at 970. Although both circuits found it unnecessary to find that the first McCarran Ferguson factor was met—the spreading of risk—§ 4-10 does meet this factor. Independent review laws spread risk by requiring the equivalent of a binding arbitration mechanism to determine which risks will be spread between the HMO and the enrollee needing medical care. Risk is spread by effectuating the terms of the insurance contract, without which there would be no risk transfer at all. *U.S. Dept. of Treasury v. Fabe*, 508 U.S. 491, 504 (1993).

The Fifth and the Seventh Circuits correctly held that independent review laws are laws regulating insurance within the meaning of ERISA's saving clause. Those courts disagreed, however, on whether a saved state independent review law is nevertheless preempted by §502(a). The Seventh Circuit reasoned that a claim to enforce the independent review decision "cannot be characterized as creating an alternative remedy scheme that conflicts with § 502(a)," because they are "not tantamount to the relief offered under § 502(a)(1)(B)." *Moran*, 230 F.3d at 971. Rather, independent review "simply adds to the contract, by operation of law, an additional dispute resolving mechanism." *Id.* at 972. The Seventh Circuit recharacterized Moran's claim as a benefits claim under ERISA §502(a) and distinguished *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987). *Id.* (citing *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 375-76 (1999)). By recharacterizing the claim, the court determined that *Pilot Life* did not require preemption. *Id.* Thus, the Seventh Circuit held the Illinois independent review law provided the rule of decision in Moran's ERISA §502(a)

claim for reimbursement. *Id.* This analysis is consistent with this Court's decision in *Ward*.[11]

Although the state *amici* concur in the Seventh Circuit's reasoning and result, there is an additional, and more fundamental, reason why § 502(a) cannot preempt a saved state insurance law. When Congress has spoken, the "task is to identify the domain expressly pre-empted, because 'an express definition of the pre-emptive reach of a statute . . . supports a reasonable inference . . . that Congress did not intend to pre-empt other matters." *Lorillard Tobacco Co. v. Reilly*, 121 S.Ct. 2404, 2414 (2001) (internal citations omitted). Application of this principle to ERISA confirms that § 4-10 of the Illinois HMO Act is expressly "saved" because it is a law regulating insurance.

Section 514(a) of ERISA provides, in pertinent part, that: "Except as provided in subsection (b) of this section, ... this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). In subsection (b), Congress expressly saves from preemption "any law of any State which regulates insurance." *Id.* § 1144(b)(2)(A). This Court has recognized that:

[11] The saving clause incorporates state law into the plan providing benefits, i.e., the mandated benefit law in *Metropolitan Life* and the notice-prejudice rule in *Ward*. Independent review provisions are incorporated into ERISA plans and supply the relevant rule of decision in a §502(a) suit. Thus, to the extent the independent review is relied upon in a §502(a) enforcement action, under *Ward*, it is not preempted.

> The ERISA saving clause, with its similarly worded protection of "any law of any State which regulates insurance," appears to have been designed to preserve the McCarran-Ferguson Act's reservation of the business of insurance to the States. The saving clause and the McCarran-Ferguson Act serve the same federal policy and utilize similar language to define what is left to the States.

Metropolitan Life, 471 U.S. at 744 n.21.[12] Thus, "[i]f a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer's insurance contracts." *Holliday*, 498 U.S. at 64.

Illinois's independent review statute regulates insurance; therefore, pursuant to the saving clause, it is not preempted by ERISA. Rush Prudential erroneously argues, however, that §4-10 is nevertheless preempted because under *Pilot Life*, § 502(a) trumps the saving clause. The Court should reject Rush Prudential's sweeping reading of *Pilot Life*, because that case did not involve a state law regulating insurance and did not address the plain meaning of the saving clause.

[12] Promptly after this Court held in *U.S. v. South-East Underwriters*, 322 U.S. 533 (1944), that insurance was interstate commerce, Congress passed the McCarran-Ferguson Act to return insurance regulation to the States. *See Fabe*, 508 U.S. 491 (1993). Since then, the business of insurance has been subject to state regulation. Federal deference to state regulation of insurance is so strong that it extends to an exemption found in the Bankruptcy Code. *See* 11 U.S.C. § 109(b)(2).

The plaintiff in *Pilot Life* sought extra-contractual damages for emotional distress and punitive and exemplary damages under Mississippi common law for failure to pay a claim. *Pilot Life*, 481 U.S. at 43. After finding that the cause related to ERISA, this Court held that Mississippi's common law tort of bad faith extended to "[a]ny breach of contract and not merely breach of an insurance contract:" *Id.* at 50. Thus, the law could not be considered an insurance law subject to ERISA's saving clause. *Id.* Consequently, *Pilot Life*'s exclusive-remedy discussion has no application to state insurance laws, because no such laws were before the Court. Indeed, the Court recognized this in *Ward*, 526 U.S. at 376 n.7. *Ward* observed that *Pilot Life* must be read in the context of a "law not specifically directed to the insurance industry and therefore not saved from ERISA pre-emption."[13] *Ward* forecloses Rush Prudential's argument that *Pilot Life* requires preemption of Illinois's independent review statute.

The plain meaning of the saving clause reflects Congress's express rejection of Rush Prudential's argument that § 502(a) preempts Illinois's independent review statute. Congress stated that "*nothing in this subchapter* shall be construed to exempt or relieve any person from any law of any State which regulates insurance." 29 U.S.C. § 1144(b)(2)(A) (emphasis added). The saving clause and § 502(a) are in the same part, the same subtitle, and the same subchapter of ERISA. It is inconceivable that Congress intended the saving

[13] *Id.* The Court also noted that the Solicitor General's brief asserted that "the insurance saving clause . . . saves state law conferring causes of action or affecting remedies" and that reliance on *Pilot Life* for a contrary result was without merit. *Id.*

clause to have no effect on laws implicating § 502(a). To the contrary, the text of ERISA demonstrates Congress's intent to create an exception from preemption for state insurance laws.

The Court's construing the saving clause as excluding insurance remedies from § 502(a) preemption would also be consistent with the Court's decision in *John Hancock*. 510 U.S. at 86. In *John Hancock*, the plaintiff asserted that ERISA's requirement that a fiduciary act "*solely* in the interest of . . . participants and beneficiaries and . . . for the exclusive purpose of . . . providing benefits," must yield to conflicting state-law requirements that an insurer managing general account assets consider the interests of, and maintain equity among, all of its contractholders, creditors, and shareholders. *Id.* at 97 (contrasting 29 U.S.C. § 1104(a) and N.Y. [INS.] LAW § 4224(a)(1)). The Court noted that "[n]o decision of this Court has applied the saving clause to supersede a provision of ERISA itself." 510 U.S. at 99 n.9 (citations omitted). Here, § 4-10 does not supercede a provision of ERISA, it complements one. The Court recognizes that complementary, dual regulation is permitted under ERISA. *Id.* at 100. To hold otherwise "would virtually read the saving clause out of ERISA." *Ward*, 526 U.S. at 376.

Independent review statutes, such as § 4-10 of the Illinois HMO Act, survive ERISA preemption because they complement ERISA. Insurance regulation serves one basic purpose—to ensure that promised benefits are provided when needed. This is done through regulation of solvency and regulation of claims practices to insure that claims can and will be paid. *See Metropolitan Life*, 471 U.S. at 729 n.2. It would defeat a fundamental purpose of state insurance law to accept

Rush Prudential's argument that any state insurance law that has the effect of requiring payment of a claim cannot be saved from preemption. Although subsection (a) of ERISA's express preemption provision is not a model of clarity, subsection (b) is. Congress explicitly excluded state insurance laws from ERISA preemption and this intent should be given effect by finding that a state independent review law such as § 4-10 is saved from preemption.

IV. Section 4-10 Does Not Conflict With ERISA.

State statutes providing independent review of the medical necessity of physicians's treatment decisions do not conflict with ERISA whether they are treated as saved insurance laws or state regulation of medical necessity that Congress did not intend for § 514(a) to preempt. Traditional conflict preemption principles require conflict preemption of state law only "to the extent it actually conflicts with federal law, that is, when it is impossible to comply with both state and federal law, or where the state law stands as an obstacle to the accomplishments of the full purposes and objectives of Congress." *Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238, 248 (1984) (citations omitted); *accord Gade v. Nat'l Solid Wastes Mgmt. Ass'n*, 505 U.S. 88, 98 (1992). A conclusion that Congress intended to preempt independent review laws requires finding that Congress "has left no room" for state regulation or that the federal interest requires that the federal system dominate state laws of the same subject. *Hillsborough County v. Automated Med. Lab., Inc.*, 471 U.S. 707 (1985).

No substantive provision in ERISA governs the provision of medically-necessary care to participants or beneficiaries. Accordingly, there is no direct conflict.

Moreover, these independent review statutes, far from standing as an obstacle to ERISA's objectives, actually further the protection of plan participants and beneficiaries by providing a check on an HMO's incentive to provide less care than a plan participant or beneficiary needs. *See Pegram*, 530 U.S. at 218–20 (discussing the structure of HMOs and their cost-controlling measures).

ERISA's principal objective is to protect plan participants and beneficiaries. *See, e.g., Boggs*, 520 U.S. at 845 (quoting *Shaw*, 463 U.S. at 90 ("ERISA is a comprehensive statute designed to promote the interests of employees and their beneficiaries.")). The text of ERISA states that its policy is "to protect . . . the interests of participants in employee benefit plans and their beneficiaries." 29 U.S.C. § 1001(b). Similarly, the purpose of independent review statutes is to protect the quality of HMO participants's healthcare. *External Review Update*, *supra* n.2 at 1. Importantly, they impose a measure of accountability on HMOs.[14] Rather than standing as an obstacle to congressional intent, state independent review statutes actually further ERISA's primary purpose.

Specifically, there is no conflict with § 503 of ERISA, which provides that participants are entitled to "a full and fair review by the appropriate named fiduciary" of a benefit denial under "regulations of the Secretary [of the Treasury]." 29

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[14] *See* The President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, *Quality First: Better Health Care for All Americans, Final Report to the President of the United States* (1998).

U.S.C. § 1133(2). This internal, administrative review is not the independent, external review contemplated by § 4-10 and thus the Illinois statute "complements rather than contradicts ERISA and the regulation." *Ward*, 526 U.S. at 377. Moreover, HMOs could comply with both regulations. Since this Court holds that "ERISA leaves room for complementary or dual federal and state regulation," there is no preemption of § 4-10 of the Illinois HMO Act due to a direct conflict. *John Hancock*, 510 U.S. at 98.

Nor does § 4-10 conflict with ERISA § 502(a). Rush Prudential maintains there is a conflict relying on *Pilot Life*, and arguing that Congress intended to preempt all civil remedies. First, the state *amici* contend that Congress would not have intended to preempt an independent review law under § 502(a) that is not preempted by ERISA's express preemption clause. *See supra*, Parts II and III. Second, Rush Prudential misconstrues this Court's holding in *Pilot Life*.

This Court's analysis in *Pilot Life* was informed by the decision in *Massachusetts Mutual Life Insurance Co. v. Russell*, 473 U.S. 134 (1985).[15] In *Russell*, this Court held that Congress did not intend to allow the federal judiciary to imply a cause of action for extra-contractual damages caused by improper or untimely processing of benefit claims. *Id.* at

[15] *Russell* concerned a claim that an insurance company administering an ERISA plan breached its fiduciary duty under ERISA by failing to promptly process the ERISA beneficiary's claim for disability benefits. The Ninth Circuit held the insurer's actions violated ERISA fiduciary duties giving rise to a federal cause of action that included compensatory damages for mental or emotional distress and punitive damages against the fiduciary. *Russell*, 473 U.S. at 138.

148. Similarly, *Pilot Life* concerned a state-law cause of action for extra-contractual damages against an ERISA plan for failure to pay benefits. The claims in *Pilot Life* were tortious breach of contract, breach of fiduciary duties, and fraud in the inducement. The plaintiff was seeking damages for failure to pay benefits, general damages for mental and emotional distress, other incidental damages, and punitive and exemplary damages. This Court held that the federal remedy provided in ERISA § 502(a) displaced these state causes of action. *Pilot Life*, 481 U.S. at 57; *see also Ingersoll-Rand*, 498 U.S. at 486 (holding that a state cause of action for wrongful discharge that duplicated a cause of action under § 502(a) for violating ERISA § 510 was preempted). Unlike the statutes in *Pilot Life* and *Russell*, however, the independent review laws do not provide a cause for action for extra-contractual damages. Nor does § 4-10 provide for any state cause of action as was the case in *Pilot Life* and *Ingersoll-Rand*. These cases, therefore, are not controlling here.

In *Pilot Life*, the Court analogized § 502(a) of ERISA to § 301 of the Labor Management Relations Act of 1942, 29 U.S.C. §§ 141–187 (LMRA).[16] The Court reasoned[17] that since the LMRA provides federalized remedies for violation of

[16] *Pilot Life*, 481 U.S. at 56 (citing 2 Senate Committee on Labor and Public Welfare, Legislative History of ERISA, 94th Cong., 2d Sess., 2359 (Comm. Print 1976)("All such actions in Federal or State Court are to be regarded as arising under the laws of the United States in similar fashion to those brought under section 301 of the [LMRA].").

[17] The Court was influenced by the brief of the United States advocating that § 502(a) be considered an exclusive remedy. The Solicitor General subsequently repudiated that analysis in *Ward*, 526 U.S. at 376 n.7.

collective bargaining agreements, so too should ERISA. In *Ingersoll-Rand*, the Court noted the parallel between § 502(a) and § 301, and held that a state cause of action was preempted because it purported "to provide a remedy for a violation of a right expressly guaranteed by § 510 and exclusively enforced by § 502(a)." *Ingersoll-Rand*, 498 U.S. at 145 (citing *Magic Chef*, 486 U.S. at 409 n.8). A closer examination of *Ingersoll-Rand*, the LMRA and the *Magic Chef* decision, however, reveals the flaw in Rush Prudential's argument that § 502(a) preempts § 4-10.

First, in *Ingersoll-Rand*, the state claim duplicated an express right guaranteed in ERISA. There is, however, no right to an independent review in ERISA. Accordingly, §4-10 does not duplicate an ERISA right and concomitant remedy and thus there is no conflict preemption.

Second, a holding that § 4-10 is preempted by § 502(a) would not comport with Congress's intent, as it thwarts Congress's fundamental purpose in enacting ERISA. The necessity for uniform interpretation of collective bargaining agreements provides the foundation for this Court's determination that the LMRA provides exclusive remedies. *Franchise Tax Bd. v. Constr. Laborers Vacation Trust*, 463 U.S. 1, 25 n.28 (1983). Congress's principal purpose in enacting ERISA was "to insure against the possibility that the employee's expectation of the benefit would be defeated through poor management by the plan administrator." *Massachusetts v. Morash*, 490 U.S. 107, 115 (1989). ERISA's stated purpose is "to protect . . . the interests of participants in employee benefit plans and their beneficiaries." 29 U.S.C. § 1001(b). Accordingly,

interpreting ERISA as synonymous with the LMRA to frustrate the legitimate expectations of beneficiaries to receive necessary medical care does not comport with congressional intent.

Third, even if § 502(a) was patterned after the LMRA, this Court has held that state law claims that do not require interpretation of collective bargaining agreements are not preempted under the LMRA. *Magic Chef*, 498 U.S. at 409–10 (state tort suit for retaliatory discharge was not preempted because "even if dispute resolution pursuant to a collective-bargaining agreement, on the one hand, and state law, on the other, would require addressing precisely the same set of facts, as long as the state-law claim can be resolved without interpreting the agreement itself, the claim is 'independent' of the agreement for § 301 pre-emption purposes"). A similar analysis of independent review laws reveals they should likewise be considered independent of an ERISA plan document for § 502(a) preemption purposes.

Independent review laws do not require interpretation of benefit plans, nor do they result in the development of differing substantive law standards applicable to ERISA plans. The issues are unique questions of medical necessity rather than plan interpretation and, thus, the concerns expressed in *Ingersoll-Rand* are not at issue. Instead, the *Magic Chef* case is more on point and § 4-10 does not run afoul of any exclusive enforcement concerns underlying this Court's decisions, even though the same set of facts may be the basis for both an independent review and a § 502(a) action.

Moreover, medical decisionmaking becomes an issue in both an independent review and a § 502(a) action only

because plans couch their coverage in terms of medical necessity. A plan cannot create ERISA preemption, however, by clever draftsmanship of a plan. Medical necessity is a question of what the "appropriate medical response" to a given "patient's constellation of symptoms." *Pegram*, 530 U.S. at 228. That appropriate medical response is not dependent on the language in a plan document, it is dependent on medical judgment. Accordingly, Rush Prudential's arguments that § 4-10 conflicts with ERISA should be rejected.

CONCLUSION

The Court should affirm the judgment of the Seventh Circuit.

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Supreme Court of the United States

RUSH PRUDENTIAL HMO, INC.,

Petitioner,

v.

DEBRA MORAN and STATE OF ILLINOIS,

Respondents.

On Writ Of Certiorari
To The United States Court Of Appeals
For The Seventh Circuit

BRIEF OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS AS AMICUS CURIAE IN SUPPORT OF RESPONDENTS

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INTEREST OF AMICUS CURIAE[1]

The National Association of Insurance Commissioners (NAIC) is a non-profit corporation comprised of the chief insurance regulators in each state, four territories and the District of Columbia. The NAIC assists these officials in the pursuit of fundamental insurance regulatory objectives, including: (1) maintaining and improving state regulation in a responsive and efficient manner; (2) maintaining the reliability of insurance business with respect to financial solidity and guarantees against loss; and (3) ensuring fair, just and equitable treatment of policyholders and claimants.[2]

The issue before this Court implicates the NAIC's objectives because it addresses whether the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001, *et seq.* (2001), preempts state independent review laws that regulate insurance within the meaning of ERISA's saving clause, § 514(b)(2)(A).

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[1] Pursuant to Supreme Court Rule 37.3(a), letters of consent from all parties to the filing of this brief have been filed with the Clerk. Pursuant to Supreme Court Rule 37.6, counsel for any party did not author this brief in whole or in part. No person or entity, other than this Amicus Curiae, made a monetary contribution to the preparation and submission of this brief.

[2] National Association of Insurance Commissioners (NAIC) Constitution, Article II. Mission Statement, 1 1997 PROC. OF THE NAT'L ASS'N OF INS. COMMISSIONERS iv (1st qtr.)

The NAIC adopted the Health Carrier External Review Model Act (Model Act), 1 MODEL LAWS, REGULATIONS AND GUIDELINES No. 75 (2000), on October 4, 1999.[3] Generally, the Model Act provides for independent review of health carrier coverage decisions based on medical judgment. By adopting this Model Act, the NAIC declared that the independent review of certain claims determinations furthers the NAIC mission – to ensure the fair, equitable and just treatment of insurance consumers. *Id.* This Court should affirm insurance regulators' ability to protect insurance consumers by affirming the United States Court of Appeals for the Seventh Circuit's decision in *Moran v. Rush Prudential HMO, Inc.*, 230 F.3d 959 (7th Cir. 2000), *cert. granted*, U.S.L.W. (U.S. June 29, 2001) (No. 00-1021).

SUMMARY OF ARGUMENT

This Court should affirm the Seventh Circuit's decision in *Moran* and hold that Illinois's independent review law, 215 ILL. COMP. STAT. 125/4-10 (2001) (Section 4-10), is not preempted by ERISA. Section 4-10 is saved as a law that "regulates insurance" within the meaning of ERISA's saving clause, § 514(b)(2)(A). The Seventh Circuit in *Moran* and the United States Court of Appeals for the

[3] *See* Br. for NAIC as Amicus Curiae in Support of Petition for Writ of Certiorari at 2-9, *Moran v. Rush Prudential HMO, Inc.*, 230 F.3d 959 (7th Cir. 2000) (No. 00-1021) (discussion of the NAIC Health Carrier External Review Model Act and state independent review laws that will be impacted by this Court's decision in this case.)

Fifth Circuit in *Corporate Health Ins. Inc. v. The Texas Dep't of Ins.*, 215 F.3d 526 (5th Cir. 2000), the only two circuit courts to address the issue of ERISA preemption of state independent review laws, were correct in concluding that state independent review laws were within the insurance saving clause.

This Court should affirm the rationale of the Seventh Circuit, and hold that state independent review laws merely add terms to insurance contracts, which are enforceable through suits under ERISA. Alternatively, if this Court should find that state independent review laws create a remedy or enforcement mechanism that supplements § 502 of ERISA, 29 U.S.C. § 1132 (2001), this Court should hold that the laws are not, nevertheless, preempted. This Court should revisit its opinion in *Pilot Life v. Dedeaux*, 481 U.S. 41 (1987), and clarify that, by its plain language, ERISA's saving clause, § 514(b)(2)(A), limits the preemptive effect of § 502.[4]

[4] The NAIC understands that Respondent may argue that Illinois's independent review law is not preempted under ERISA because it is a law regulating health care, a subject of traditional state regulation, and therefore does not "relate to" an ERISA Plan. In light of this Court's decision in *Pegram v. Herdrich*, 530 U.S. 211, 219 (2000), we think that this argument has merit. The NAIC, however, has chosen to address those issues involving the regulation of insurance – our unique area of expertise.

ARGUMENTS

A. Illinois's Independent Review Law Regulates Insurance Within the Meaning of ERISA's Saving Clause.

1. The circuit courts agree that independent review laws are saved as laws regulating insurance.

Only two federal courts of appeals have addressed the issue of ERISA preemption of state independent review laws, the Fifth Circuit in *Corporate Health* and the Seventh Circuit in *Moran*. While they reached opposite conclusions about ERISA preemption, both concluded that the state's independent review law regulated insurance within the meaning of ERISA's saving clause, § 514(b)(2)(A). The Fifth Circuit held that the Texas independent review law "meet[s] the common-sense test of the saving clause" and "satisf[ies] the second and third prongs of the McCarran-Ferguson test." *Corporate Health*, 215 F.3d at 538. The Seventh Circuit likewise held that the Illinois law "regulates insurance under a common sense understanding" and clearly "meets at least two of the McCarran-Ferguson factors." *Moran*, 230 F.3d at 969.

In addition, this Court in *Unum v. Ward*, 526 U.S. 358 (1999), stated that the issue of whether California's notice-prejudice rule was a law that regulates insurance within the meaning of ERISA's saving clause, was an issue "heavily dependent on state law." *Id.* at 368. Illinois's independent review law, Section 4-10, applies to health maintenance organizations (HMOs) and according to the Seventh Circuit, HMOs are in the business of insurance under Illinois law. *See Anderson v. Humana, Inc.*, 24 F.3d 889, 892 (7th Cir. 1994); *In the Matter of Estate of Medcare HMO*, 998 F.2d 436, 444-46 (7th Cir. 1993). Consequently, this Court should defer to the circuit courts and

find that Section 4-10 regulates insurance within the meaning of ERISA § 514(b)(2)(A).

2. Illinois's independent review law regulates insurance from a common sense perspective.

Petitioner asserts that Illinois's independent review law fails to "regulate insurance" within the meaning of ERISA's saving clause, ERISA § 514(b)(2)(A). Petitioner focuses on the "common sense test," Br. for Pet'r at 36-40, and whether Section 4-10, because it applies to HMOs,[5] is a law directed specifically at the insurance industry.[6] Clearly, HMOs are insurers. HMOs are considered insurers under Illinois law.[7] The location of the HMO Act in the Insurance Chapter of the Illinois Code supports the common sense view that HMOs are insurers.[8] The Secretary of the Department of Labor, who is charged with interpreting and enforcing all provisions of Title I of ERISA, has taken the position that HMOs are insurers.[9]

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[5] "Each Health Maintenance Organization shall provide a mechanism for the timely review by a physician . . . in the event of a dispute between the primary care physician and the Health Maintenance Organization regarding the medical necessity of a covered service. . . . " 215 ILL. COMP. STAT. 125/4-10 (2001).

[6] The "common sense view of the word 'regulates' would lead to the conclusion that in order to regulate insurance, a law must not just have an impact on the insurance industry, it must be specifically directed toward that industry." Br. for Pet'r at 37, citing *Pilot Life v. Dedeaux*, 481 U.S. 41, 50 (1987).

[7] *See* discussion *supra* at 4.

[8] 215 ILL. COMP. STAT. 125/1-1, *et seq.* (2001).

[9] *See* Br. for Secretary of Labor as Amicus Curiae at 14, *Moran*, 230 F.3d 959 (No. 99-2574); Br. for the U.S. as Amicus

Several circuit courts have also concluded that HMOs are insurers.[10] Indeed, this Court has stated that HMOs are risk-bearing entities that function much like traditional insurers. *See Pegram v. Herdrich*, 530 U.S. 211, 219 (2000).

Petitioner asserts, however, that the Illinois definition of "HMO" applies to entities that have administrative service only contracts with self-funded employers because Illinois law allows HMOs to "devolve all risk onto their providers." Br. for Pet'r at 38. The fact that an HMO transfers ("devolves") risk to its providers does not mean that the HMO is not an entity engaged in the business of insurance subject to state regulation. An insurer need not retain the risk it assumes in order to be engaged in the business of insurance. In fact, indemnity insurers often reinsure their risk.[11] This spreading of risk

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Curiae at 23-24, *Pegram v. Herdrich*, 530 U.S. 211 (2000) (No. 98-1949); Br. for Secretary of Labor as Amicus Curiae at 7-10, *Washington Physician Serv. Ass'n v. Gregoire*, 147 F.3d 1039 (9th Cir. 1998) (No. 97-35536); Br. for Secretary of Labor as Amicus Curiae at 19-20, *Express Scripts v. Wenzel*, 262 F.3d 829 (8th Cir. 2001) (No. 00-2788).

[10] *See Ocean State Physicians Health Plan, Inc. v. Blue Cross and Blue Shield*, 883 F.2d 1101, 1108 (1st Cir. 1989); *Anderson v. Humana, Inc.*, 24 F.3d 889, 892 (7th Cir. 1994); *Gregoire*, 147 F.3d at 1045-46; *Corporate Health Ins. Inc. v. The Texas Dep't of Ins.*, 215 F.3d 526, 538 (5th Cir. 2000); *Kentucky Ass'n of Health Plans, Inc. v. Nichols*, 227 F.3d 352, 364-65 (6th Cir. 2000); *but see, O'Reilly v. Ceuleers*, 912 F.2d 1383, 1389 (11th Cir. 1990).

[11] *See* ROBERT W. KLEIN, NAT'L ASS'N OF INS. COMMISSIONERS EDUC. & RES. FOUND., A REGULATOR'S INTRODUCTION TO THE INSURANCE INDUSTRY at 3-13 (1999) ("Insurers purchase reinsurance to reduce their risk."); *see also* NAC REINSURANCE CORP., REINSURANCE CONTRACTS CONTENT AND REGULATION at 37 (2d ed. 1993) (practice of fronting, where one insurer cedes all its

does not alter the nature of the original insurance transaction – both the HMO and the indemnity insurer have assumed the risk of a subscriber's health care costs in exchange for a fixed fee.

In fact, it is this original transfer and spreading of risk, common to both indemnity insurers and HMOs, that this Court has referenced as being a "distinguishing feature of insurance," *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 211-212 (1979). Both HMOs and indemnity insurers, in exchange for a payment from the policyholder, accept the risk of the policyholder's medical costs. This transfer of risk of loss from the insured to the insurer is the same whether the insurer is an HMO or indemnity company. As the Secretary points out in its amicus brief in *Washington Physicians Serv. Ass'n v. Gregoire*, "like an insurance concern, an HMO bears the risk of the need for medical assistance. And like an insurance concern, an HMO spreads this risk among its subscribers." Brief for Secretary of Labor as Amicus Curiae at 7-8, *Gregoire*, 147 F.3d 1039 (9th Cir. 1998) (No. 97-35536). An HMO that accepts and transfers risk is engaging in the business of insurance.[12] It makes scant sense to place such significance on the method by which an HMO chooses to fulfill its obligation to subscribers. Whether by

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risk to an assuming insurer, does not alter either parties' obligations under their respective contracts.)

[12] "Insurance is an arrangement for transferring and distributing risks." *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 211 (1979), citing G. Richards, the Law of Insurance § 2 (W. Freedman 5th ed. 1952).

employing providers or entering into contractual arrangements, such arrangements fail to alter the fundamental insurance contract with the subscribers.[13]

Illinois's law, by regulating entities that provide or arrange for health care plans, ensures that entities are not able to evade state insurance law through creative corporate and contract structures. Even if, through some such creative structure, an HMO entered into a three party contract with an employer where it provided a network that assumed all the risk of providing health care and the HMO only assumed administrative responsibility, the Illinois law would still regulate the HMO and probably, additionally, the provider network.[14] Under this scenario, both the HMO and the provider network are providing or arranging for a health care plan, covered under the definition of HMO under Illinois law. Such regulation is entirely proper and good public policy because otherwise entities could avoid state insurance regulation by dividing the traditional functions of an insurer among distinct corporate entities.

Regardless of the risk sharing arrangements an HMO may have with its providers, the plain language of the Illinois statute makes clear that an HMO does not include

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[13] *See In the Matter of Estate of Medcare HMO*, 998 F.2d 436, 444 n.7 (7th Cir. 1993) ("The distinction between cash indemnification and provision of service in kind is not, from the perspective of enrollees, very marked. The enrollees' health care costs are met by the organization in question under either scenario.")

[14] *See infra* at 9 (definition of "Health maintenance organization" 215 ILL. COMP. STAT. ANN. 125/1-2 (2001)).

an entity involved in an administrative services only contract with a self-funded employer. Illinois law defines HMO as "any organization formed under the laws of this or another state to provide or arrange for one or more health care plans under a system which causes any part of the risk of health care delivery to be borne by the organization or its providers." 215 ILL. COMP. STAT. § 125/1-2(9) (2001). According to this definition, "arranging" involves risk being borne by the HMO or "its" providers. If the employer retains the risk, then the HMO is clearly not providing or arranging for a health care plan where risk is being borne by an entity other than the employer as is required by the Illinois definition of HMO. If the risk is not being borne by the employer, then the employer is not self-funding. Therefore, this definition applies exclusively to HMOs that are insurers.

The attempt of the Petitioner to misconstrue the definition of HMO in the Illinois Act to include administrative services only contracts with self-funded employers cannot succeed in any event. In addition to the plain language of the definitions in the law, this Court held in *FMC Corp. v. Holliday*, 498 U.S. 52, 65 (1990) that a state insurance law will only be invalidated to the extent that it applies to self-funded plans. *Id.*

3. Illinois's independent review law regulates insurance within the meaning of the three McCarran-Ferguson factors.

Petitioner also asserts that the Illinois law fails to satisfy any of the three factors[15] employed to determine whether a practice regulates the "business of insurance" within the meaning of the McCarran-Ferguson Act, 15 U.S.C. § 1012 (2001). *See* Br. for Pet'r at 40. It is important to remember that the McCarran-Ferguson Act does not contain identical language to ERISA. The McCarran-Ferguson Act makes reference to the "business of insurance." This Court in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 714 (1985) explained that "[c]ases interpreting the scope of the McCarran-Ferguson Act have identified three criteria relevant to determining whether a particular *practice* falls within that Act's reference to the 'business of insurance.' " *Id.* at 743 (emphasis added). This is a different inquiry than whether a state law "regulates insurance" within the meaning of ERISA's saving clause. ERISA makes reference to laws that "regulate insurance" and, through the inclusion of the "deemer" clause, § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B), makes "explicit Congress' intention to include laws that regulate insurance contracts within the scope of the insurance laws preserved by the saving clause." *Metropolitan Life*, 471 U.S. at 741. ERISA's reservation of state

[15] The three factors are: (1) whether the law has the effect of transferring or spreading a policyholder's risk; (2) whether the law is an integral part of the policy relationship between the insurer and the insured; and (3) whether the law is limited to entities within the insurance industry. *Unum v. Ward*, 526 U.S. 358, 373-375 (1999).

insurance regulation is explicitly broader in its scope than the McCarran-Ferguson Act, otherwise it would not have been necessary for Congress to make reference to laws regulating insurance contracts in the deemer clause.[16] Therefore, as this Court makes clear in *Ward*, the three McCarran-Ferguson factors are "checking points or guideposts" to consider, "not separate essential elements . . . that must each be satisfied" to save a state law within the meaning of ERISA § 514(b)(2)(A). *Ward*, 526 U.S. at 373-374.

In any event, Illinois's independent review law satisfies the three McCarran-Ferguson factors. First, Section 4-10 has the effect of transferring or spreading a policyholder's risk. This Court in *Metropolitan Life* held that Massachusetts's mental health law regulated insurance within the meaning of ERISA's saving clause because "it was intended to effectuate the legislative judgment that the risk of mental health should be shared." 471 U.S. at 743. According to the Secretary of Labor in its amicus brief before the Seventh Circuit in *Moran*, the Illinois independent review law similarly spreads risk by requiring an HMO to use a certain procedure for determining which claims to pay. *See* Br. for Secretary of Labor as Amicus Curiae at 12, *Moran* (No. 99-2574). This procedure is an integral part of risk spreading because it determines which risks will be spread and in what manner. *Id.* Indeed, HMOs factor these risks into setting the premiums for their contracts, which is a central element of risk spreading. *Id.* at 13. Section 4-10 also effectuates the

[16] *See also* Br. for Secretary of Labor as Amicus Curiae at 7-10, *Gregoire*, 147 F.3d 1039 (9th Cir. 1998) (No. 97-35536).

transfer of risk, as it regulates the performance of the terms of the insurance contract by mandating independent physician review when there is a coverage dispute based on medical necessity. As this Court in *U.S. Dep't of Treasury v. Fabe*, 508 U.S. 491 (1993) explained, "without performance of the terms of the insurance policy, there is no risk transfer at all." *Id.* at 504.

Second, the Illinois independent review law is an integral part of the policy relationship between the insurer and the insured. Similar to the notice-prejudice rule at issue in *Ward*, the Illinois independent review law goes to the heart of the insurer-insured relationship by dictating the process whereby the HMO decides whether benefits are owed to the insured. *See* 526 U.S. at 374-375. It provides an insured with a contractual right to an independent review process. This Court has "repeatedly held that state laws mandating insurance contract terms are saved from preemption." *Ward*, 526 U.S. at 375-376 (citing *Metropolitan Life*, 471 U.S. at 758) ("Massachusetts' mandated-benefit law is a 'law which regulates insurance' and so is not preempted by ERISA as it applies to insurance contracts purchased for plans subject to ERISA.")

This Court has also stated, in *Metropolitan Life*, that "[s]tatutes aimed at protecting or regulating [the relationship between an insurer and insured], directly or indirectly, are laws regulating the 'business of insurance.' " 471 U.S. at 744 (citation omitted). Section 4-10 regulates the relationship between an insurer and an insured by requiring independent physician review of coverage determinations made by managed care organizations,

based on whether a covered service is medically necessary, 215 Ill. Comp. Stat. 125/4-10 (2001).

Third, for all the reasons that Section 4-10 regulates insurance from a common sense perspective, the Illinois law is limited to entities within the insurance industry.

B. Illinois's Independent Review Law does not Provide a Remedy that Conflicts with § 502, and Even if it is a Remedy, it is Subject to the Saving Clause.

1. Illinois's independent review law does not provide an alternative enforcement mechanism in conflict with ERISA § 502.

Petitioner asserts that Section 4-10 creates an alternative enforcement mechanism to ERISA § 502, which was intended to be exclusive. Br. for Pet'r at 19-36. Under ERISA § 502(a)(1)(B), a beneficiary is able to "recover benefits due under the terms of the plan" or "enforce his rights under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B) (2001). Section 4-10 does not provide an alternative to this ERISA remedy, because under the Illinois statute an independent reviewer cannot enforce his coverage determination. Illinois's independent review law is no different from other state laws that are not preempted. Section 4-10 is like the mandated benefits law at issue in *Metropolitan Life*, which adds covered benefits to the terms of an insured ERISA plan. Section 4-10 is also indistinguishable from the notice-prejudice rule at issue in *Ward*. Illinois's independent review law changes the terms of an insured plan by adding procedural protections to assure that covered benefits promised by

the insurer are not misconstrued by decision makers whose fortunes are closely tied to the insurer.

Just as there would be no basis for challenging other state laws aimed at insurance carriers that adjust the method by which carriers decide claims, there is no basis for challenging Illinois's independent review law. The state is merely prescribing the qualifications of the person who has the authority to decide a type of claim. As the Secretary stated in its Brief before the Seventh Circuit, Section 4-10 "neither provides participants with an additional remedy where the HMO refuses to provide the covered service nor an alternative forum in which a participant can obtain the service," Br. for Secretary of Labor as Amicus Curiae at 18, *Moran* (No. 99-2574). Petitioner contends that the preemptive reach of § 502 requires that federal substantive law be applied in § 502 cases. Br. for Pet'r at 25-26 n.6. This Court has already rejected that view – implicitly in *Metropolitan Life*, 724 U.S. at 741, and explicitly in *Ward*, 526 U.S. at 377. If state mandates of the sort endorsed in *Metropolitan Life* are permitted, necessarily state substantive law must be applied to determine whether those mandates are being complied with in a particular case. As in *Ward*, where a participant could only enforce the notice-prejudice rule through a suit pursuant to § 502(a)(1)(B) of ERISA, the determination of the state-approved decision maker here, can only be enforced through ERISA. *See* Br. for Secretary of Labor as Amicus Curiae at 18, *Moran* (No. 99-2574). Section 4-10 does not replace ERISA's remedies, rather it provides the "relevant rule of decision," for a § 502 suit. *See Ward*, 526 U.S. at 377; *see also John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86, 98-99 (1993) ("ERISA leaves

room for complementary or dual federal and state regulation. . . . ")

Petitioner asserts that Section 4-10 impermissibly conflicts with the deferential standard of review of HMO benefits determinations to which HMOs are entitled under *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 111 (1989). Br. for Pet'r at 17. *Firestone* did not hold that ERISA requires deference to insurers or any plan administrators making benefit determinations. This Court in *Firestone* held that courts would presumptively review ERISA benefit determinations de novo, but that "a deferential standard of review [is] appropriate" when the decision maker is given "discretionary powers." 489 U.S. at 115.[17] This holding, however, does not prevent states from enacting laws that prevent insurers from writing policies that grant to themselves the amount of discretion that entitles them to deferential review. Without such discretion, *Firestone* requires judicial de novo review. By

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[17] This holding was qualified when this Court noted that "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'factor in determining whether there is an abuse of discretion.' " *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989) (quoting RESTATEMENT (SECOND) OF TRUSTS § 187, cmt. d (1959)). Since *Firestone*, the circuits have struggled to apply this command to benefit decisions by insurance carriers who, by definition, labor under a structural conflict of interest. The United States Court of Appeals for the Third Circuit in *Pinto v. Reliance Standard*, 214 F.3d 377 (3rd Cir. 2000), reviewed the circuits' efforts and the resulting multiple circuit splits. The Third Circuit decided "to apply the arbitrary and capricious standard, and integrate conflicts as factors in applying that standard, approximately calibrating the intensity of our review to the intensity of the conflict." *Id.* at 393.

shifting discretion to independent decision makers, the Illinois law will result in deference to the independent reviewer rather than the insurance company, which has a financial incentive to deny claims.

Under ERISA's saving clause, § 514(b)(2)(A), states are entrusted with the regulation of insurance and are free to determine the contents of insurance contracts. *See Metropolitan Life*, 471 U.S. at 741 (Congress intended to include laws that regulate insurance contracts within the scope of ERISA's saving clause.) Illinois's independent review law is just such a regulation of insurance contracts. By passing its independent review law, the Illinois legislature decided that insurers do not deserve deference when they are engaged in medical decision making to determine insurance coverage.

Petitioner repeatedly asserts in its brief that Section 4-10 is just a form of binding arbitration. Br. of Pet'r at 21, 22, 25, 27, 31 n.10. If so, Section 4-10 is surely not a remedy that conflicts with ERISA's remedial scheme.[18] This Court has repeatedly espoused the federal policy favoring arbitration. *See Circuit City Stores, Inc. v. Saint*

[18] Petitioner also argues that Illinois's independent review law conflicts with ERISA's fiduciary requirements. Br. for Pet'r at 22 n.5. This argument is illogical. Independent review no more conflicts with ERISA's fiduciary requirements than does arbitration. A benefit determination can be subject to a "full and fair review by an appropriate named fiduciary" as well as be subject to independent review. The one does not preclude the other. *See John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86, 98 (1993). ("ERISA leaves room for complementary or dual federal and state regulation. . . . ")

Clair Adams, 121 S. Ct. 1302, 1307 (2001); *Gilmer v. Interstate/Johnson Lane Corp.*, 500 U.S. 20, 24 (1991); *Shearson/American Express Inc. v. McMahon*, 482 U.S. 220, 226 (1987); *Moses H. Cone Mem'l Hosp. v. Mercury Constr. Corp.*, 460 U.S. 1, 24-25 (1983). This Court, in *Pilot Life*, mentions that ERISA § 502 "was modeled on the exclusive remedy provided by § 301 of the Labor Management Relations Act (LMRA), 61 Stat. 156, 29 U.S.C. § 185," 481 U.S. 41, 52.[19] This Court has never considered arbitration clauses to conflict with the exclusive remedies in LMRA § 301. *See United Steelworkers v. Warrior & Gulf Navigation Co.*, 363 U.S. 574, 581 (1960). Additionally, this Court held that a provision for exclusive federal jurisdiction in another federal statute did not prohibit arbitration. *See Shearson/American Express Inc. v. McMahon*, 482 U.S. 220, 227-229 (1987) (exclusive federal jurisdiction provision in Securities Exchange Act of 1934 does not prohibit arbitration). Consistent with these holdings, ERISA benefit claims have been held to be arbitrable, *see Graphic Communications Union, District Council No. 2 AFL-CIO v. GCIU-Employer Retirement Benefit Plan*, 917 F.2d 1184 (9th Cir. 1990), and most circuits that have considered it have held that even statutory claims under ERISA are arbitrable. *See Williams v. Imhoff*, 203 F.3d 758 (10th Cir. 2000); *Bird v. Shearson Lehman/American Express, Inc.*, 926 F.2d 116 (2d

[19] There are notable differences between the Labor Management Relations Act (LMRA) § 301, 29 U.S.C. § 185 (2001), and the Employee Retirement Income Security Act (ERISA) § 502, 29 U.S.C. § 1132 (2001). These differences, however, go to show that because of ERISA's saving clause, § 502 was never intended to limit remedies to the same extent as § 301. *See* discussion *infra* at 25-26.

Cir. 1991); *Pritzker, et al. v. Merrill Lynch, Pierce, Fenner & Smith Inc.*, 7 F.3d 1110 (3rd Cir. 1993); *Arnulfo P. Sulit, Inc. v. Dean Witter Reynolds, Inc.*, 847 F.2d 475 (8th Cir. 1988); *but see Amaro v. Bernard*, 618 F.2d 559 (9th Cir. 1980).

The fact that Illinois's independent review is imposed by state law rather than voluntarily undertaken by an insurer does not alter the conclusion that arbitration does not conflict with ERISA § 502. The Federal Arbitration Act (FAA), 9 U.S.C.S. § 1, *et seq.* (2001) itself makes enforceable agreements to arbitrate, and the Illinois law does nothing more than impose a requirement on insurers that they agree with their insureds to engage in a particular kind of state sanctioned arbitration. The insurer's agreement with the insureds is not any less an enforceable agreement because the state dictates its terms; state insurance regulations saved from preemption by ERISA always alter or control the terms of the agreement between an insurer and its insureds. *See Metropolitan Life*, 471 U.S. at 741; *Ward*, 526 U.S. at 375-376. According to ERISA's saving clause, states are free to impose requirements directly on insurers, and consequently, indirectly on plans. *See FMC Corp.*, 498 U.S. at 64. Illinois's independent review law is a law that regulates insurance within the meaning of ERISA's saving clause. Because arbitration does not conflict with the remedial scheme of either the LMRA or ERISA, a state law like Illinois's independent review law, which imposes an arbitration-like procedure, should also not be preempted.

Even if state insurance laws requiring "involuntary" independent review are viewed as outside the specific protection of the FAA, but "merely" within the ambit of the insurance saving clause, the analogy to arbitration

clauses still demonstrates the absence of any conflict with ERISA. State regulation of insurance is as much a favored federal policy under the McCarran-Ferguson Act as is arbitration under the FAA. *See Smith v. Pacificare Behavioral Health of California, Inc.*, 2001 Cal. App. LEXIS 842 at *23-*28 (October 25, 2001) (citing *SEC v. National Securities, Inc.*, 393 U.S. 453, 458-459 (1969)). Furthermore, arbitration under the FAA is saved from preemption under ERISA § 514(d), 29 U.C.S. § 1144(d), which is similar in structure to the saving clause under ERISA § 514(b)(2)(A). ERISA § 514(d) states that "[n]othing in this title shall be construed to alter, amend, modify, invalidate, impair or supersede any law of the United States . . . " and similarly, § 514(b)(2)(A) states that " . . . nothing in this title shall be construed to exempt or relieve any person from any law of any state which regulates insurance. . . . " The arbitration cases cited above demonstrate that a dispute resolution mechanism saved from preemption by the federal law saving clause, which perfectly parallels the insurance saving clause, can be harmonized with ERISA's assertedly exclusive remedial provisions. If the enforcement of arbitration agreements does not conflict with ERISA, then neither does the enforcement of state mandated independent review.

2. Even if Illinois's independent review law is a remedy, it is saved from preemption.

This Court should reaffirm the intended role of the "saving clause" in ERISA by clarifying the relationship between the civil remedies provided in ERISA § 502 and

the "saving clause" in ERISA § 514(b)(2)(A), which prohibits any construction of title I of ERISA which would "relieve any person from any law of any State which regulates insurance. . . . " 29 U.S.C. § 1144(b)(2)(A) (2001). Petitioner argues that Illinois's independent review law, because it adds to ERISA's "exclusive remedies" under § 502, undermines the statutory purpose of federal uniformity in the administration of ERISA plans. Br. for Pet'r at 19. This argument fails with respect to state laws that regulate insurance. This Court acknowledged in *Metropolitan Life*, that "disuniformities are the inevitable result of the congressional decision to 'save' local insurance regulation." 471 U.S. at 747.

a. *Pilot Life* did not take into account the presumption against preemption, which has informed this Court's recent preemption opinions.

This Court's observation in *Pilot Life* that laws regulating insurance cannot supplement the remedies provided by § 502 of ERISA was dicta. *See* 481 U.S. at 54. *Pilot Life* did not involve a law that regulated insurance within the meaning of ERISA's saving clause. *Id.* at 51. Thus, it was not necessary for this Court in *Pilot Life* to say that Congress intended that all remedies that relate to ERISA plans, regardless of whether or not they regulate insurance, are to be the exclusive vehicle for beneficiary recovery. *Id.* at 52.[20]

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[20] This Court in *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987), also discussed the exclusive nature of ERISA's remedies under § 502(a)(1)(B). *Taylor*, like *Pilot Life*, did not involve a state law that regulates insurance. *Id.* at 62. Consequently, this Court in *Taylor* had no occasion to consider whether the otherwise exclusive nature of ERISA § 502 is limited by ERISA's saving clause, § 514(b)(2)(A).

Furthermore, *Pilot Life* did not take into account the presumption against preemption, which has informed this Court's recent preemption opinions. In light of the post-*Pilot Life* recognition of the importance of preserving state law, the intended role of ERISA's saving clause should be clarified so that state laws that regulate insurance are not preempted merely because they provide a remedy. This Court's recent ERISA preemption cases emphasize Congress's intent to reserve to the states those laws that are part of their historic police powers.

This Court has recognized that insurance is one of the areas that is part of the historic police powers of the states. *See New York State Conference of Blue Cross Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1985). The United States observed, in its Brief as Amicus Curiae in *Ward*, that this Court's recent recognition of this presumption against preemption reinforces the force of the plain meaning of ERISA's saving clause.[21] In light of the

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[21] "[The] force of the savings provision's express term is reinforced by the Court's frequent recognition – particularly in recent cases – that ERISA's preemption provisions must be read against the background of the 'assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress.' " Br. for U.S. as Amicus Curiae at 30-31, *Ward*, 526 U.S. 358 (No. 97-1868), (citing *New York Conference of Blue Cross Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995)); *see also De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S.

presumption against preemption, this Court should clarify that ERISA § 514(b)(2)(A), ERISA's saving clause, saves state laws that regulate insurance, even if they are alternative remedies to ERISA § 502.[22] Accordingly, the language in *Pilot Life* regarding Congress's intent for ERISA's remedies to be exclusive should be limited to state laws that relate to an ERISA plan, but are outside the scope of the saving clause. *See* Br. for U.S. as Amicus Curiae at 28, *Ward* (No. 97-1868); *see also Franklin H. Williams Ins. Trust v. Travelers Ins. Co.*, 50 F.3d 144 (2d Cir. 1995); *but see Kanne v. Connecticut Gen. Life Ins. Co.*, 867 F.2d 489 (9th Cir. 1988); *In re Life Ins. Co. of N. Am.*, 857 F.2d 1190, 1194-1195 (8th Cir. 1988).

b. Under the plain language of ERISA, the saving clause, § 514(b)(2)(A), limits the preemptive effect of § 502.

ERISA's express preemption provision, § 514, explains the relationship between ERISA and other laws. Section 514(a) states that, "[e]xcept as provided in subsection (b) of this section, the provisions of this title [title I] and title IV shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan. . . . " 29 U.S.C. § 1144(a) (2001). This Court

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806, 813 n.8 (1997), *California Div. of Labor Standards Enforcement v. Dillingham Const. N.A.*, 519 U.S. 316, 325 (1997).

[22] *See Franklin H. Williams Ins. Trust v. Travelers Ins. Co.*, 50 F.3d 144, 151 (2d Cir. 1995) (the Second Circuit explained that "[i]t would be quixotic to rule that a claim under a state statute that is saved from ERISA preemption . . . may nonetheless be enforced only via ERISA provisions and remedies.")

has often described the "expansive sweep" of this provision. *See Pilot Life*, 481 U.S. at 47 (citations omitted).

Congress, however, "substantially qualified" the otherwise sweeping federal preemption of ERISA § 514(a) by including the saving clause, ERISA § 514(b)(2)(A). *See Metropolitan Life*, 471 U.S. at 724. ERISA's saving clause states that "[e]xcept as provided in subparagraph (B),[23] *nothing in this title* shall be construed to exempt or relieve any person from any law of any State which regulates insurance . . . " 29 U.S.C. § 1144(b)(2)(A) (2001) (footnote added, emphasis added).[24] On its face, ERISA preempts state laws that relate to ERISA plans, *unless* they regulate insurance. This Court supported this interpretation in *Metropolitan Life* and in *Pilot Life* before the issue of § 502 is discussed. *See* 471 U.S. at 733, 735; 481 U.S. at 47.

By the plain language of the statute, ERISA § 502 is subject to the saving clause. The saving clause provides that nothing in title I, which includes § 502, shall be construed to exempt or relieve any person from *any law* of any state which regulates insurance. Section 514 is the only place in ERISA that contains preemption language. Clearly, if Congress intended to save all laws that regulate insurance from preemption, except those that provide remedies, it would have said so in § 514. Section 514(b)(2)(A) already includes one exception, subsection

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[23] Referencing ERISA's deemer clause, § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B), which provides that a state cannot deem an ERISA plan an insurer for the purpose of regulating it. The deemer clause is not at issue in this case.

[24] Laws that regulate banking and securities are also exempted from the preemptive scope of § 514(b)(2)(A).

(B), for laws that deem ERISA plans to be insurers. Surely, Congress would have included another exception, if it meant to provide one.

This Court in *Pilot Life* stated that the comprehensive nature of the language and structure of § 502 "provide[s] strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly." 481 U.S. at 54 (citing *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985)). To apply this statement to all state laws, including those that regulate insurance within the meaning of § 514(b)(2)(A), unjustifiably discounts the language and structure of the entire ERISA statute, and the saving clause in particular. This Court should reaffirm the plain language of ERISA and clarify that § 502 provides the exclusive remedy only where a state law that relates to an ERISA plan is not within § 514's saving clause. *See Ward*, 526 U.S. at 376 n.7 (acknowledging without deciding Government's argument to same effect). This Court should not resort to legislative history where the words of the statute are plain. *See Harris Trust & Saving Bank v. Salomon Smith Barney Inc.*, 120 S. Ct. 2180, 2190 (2000) (citations omitted). As explained below, the legislative history of § 502 is an unreliable guide to the proper interpretation of the saving clause.

c. The legislative history of ERISA is misleading because the analogy to § 301 of LMRA is flawed.

In *Pilot Life*, this Court reasoned that, based on the legislative history of ERISA, Congress intended to federalize ERISA remedies under § 502 the same way that § 301 of LMRA had federalized remedies for violation of collective bargaining agreements. 481 U.S. at 55. This Court therefore concluded that the federal remedies available under § 502 displace state causes of action. *Id.* at 56. The obvious and fundamental differences between LMRA and ERISA warrant reconsideration of this conclusion. The LMRA governs the relationship between labor unions and employers, which is a wholly federal body of law. ERISA, with the inclusion of the "saving clause," clearly contemplates that both state and federal laws apply to insured ERISA plans. *See Metropolitan Life*, 471 U.S. at 727-747.

The United States' position with respect to the role of § 502 has changed since *Pilot Life*. *See*, Br. for U.S. as Amicus Curiae at 25-32, *Ward* (No. 97-1868). The United States' amicus brief in *Ward* pointed out that LMRA does not contain a provision comparable to the "saving clause" in ERISA. *Id.* at 31. Therefore, "Congress' intent to pattern suits under Section 502 on suits under Section 301 of the LMRA . . . does not bear directly on the preemption of a state law cause of action or remedy that 'regulates insurance.' " *Id.* The Secretary of the Department of Labor acknowledged in its amicus brief in *Moran*, that the "analogy of the LMRA to ERISA [in *Pilot Life*] was not completely well-founded." Br. for the Secretary of Labor as

Amicus Curiae at 19-20, *Moran* (No. 99-2574). The Secretary pointed out that the LMRA has been "broadly interpreted to occupy the whole field of contractual relations between employers and labor organization, whereas § 514(b)(2)(A) . . . makes clear that Congress did not intend to preempt entirely every state cause of action relating to such plans." *Id.* (citing *Franchise Tax Bd. v. Construction Laborers Vacation Trust*, 463 U.S. 1, 25 (1983)).

This Court should not read ERISA's legislative history as limiting the saving clause, recognizing that the rationale in the second half of *Pilot Life* was based, in part, on legislative history that supported an incomplete comparison between ERISA and LMRA.

CONCLUSION

For the foregoing reasons, this Court should affirm the decision of the Seventh Circuit and hold that the Illinois independent review law is not preempted by

ERISA because it is a law that regulates insurance within the meaning of the saving clause, whether or not it is a remedy.

Respectfully submitted,

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No. 00-1021

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IN THE

Supreme Court of the United States

RUSH PRUDENTIAL HMO, INC.,

Petitioner,

v.

DEBRA C. MORAN AND STATE OF ILLINOIS,

Respondents.

ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

BRIEF OF *AMICI CURIAE* TEXAS WATCH AND JACQUELINE BURROSS IN SUPPORT OF RESPONDENTS

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STATEMENT OF INTEREST

Amici curiae are Texas Watch and Jacqueline Burross.[1]

Texas Watch is an advocacy organization that serves to protect consumers by encouraging fair and professional treatment from insurance companies and HMOs. Both Texas Watch's constituency and the individual *amicus* are directly affected by the issues raised in the petition for writ of certiorari pertaining to the scope of ERISA preemption of the Illinois HMO Act and its independent-review provisions in that Texas has a similar statute, ERISA's preemptive effect on which may also come before this Court.[2]

Ms. Burross is an individual who, like Debra Moran, was denied treatment by her HMO on alleged "medical necessity" grounds, and was one of 695 successful independent reviews conducted in Texas since 1997.[3] Ms. Burross suffered from lymphedema in 1997 and 1998, during which time her HMO paid from her treatment. In 1998, she was discovered to have breast cancer, which resulted in the removal of her lymph nodes. Ms. Burross' lymphedema worsened. Nonetheless, her HMO began to deny coverage

1. This *amici curiae* brief filed in support of the Respondents was funded solely by the *amici* and authored entirely by counsel for the *amici*. Pursuant to this Court's Rule 37.3(a), letters of consent from all parties to the filing of this brief are being Lodged herewith.

2. *Corporate Health Ins., Inc. v. Texas Dept. of Ins.*, 215 F.3d 526 (5th Cir. 2000), *reh'g denied*, 220 F.3d 641 (2000), *petition for writ of certiorari filed*, 69 U.S.L.W. 3317 (Oct. 24, 2000) (No. 00-665). Texas Watch has also filed an *amici curiae* brief supporting the State Petitioners' application for writ of certiorari in *Corporate Health*.

3. Pursuant to the February 2001 IRO statistics available from the Texas Department of Insurance, HMOs were found to be wrong in making their medical decisions 58% of the time.

for Ms. Burross' lymphedema treatments, despite the recommendations of her oncologist.

As a result of her HMO's denial of these medically necessary treatments, and not financially capable of paying for the treatments herself, Ms. Burross filed an independent review organization ("IRO") appeal with the Texas Department of Insurance. The IRO decided in Ms. Burross' favor, and directed her HMO to provide the medically necessary treatments for her lymphedema, treatments she continues to receive on a periodic basis.

Amici support the Respondents, who seek affirmance of the Seventh Circuit's decision in *Moran v. Rush Prudential HMO, Inc.*, 230 F.3d 959 (7th Cir. 2000), *cert. granted*, __ U.S. __, 150 L. Ed. 2d 749 (2001) (No. 00-1021). That court correctly held that an Illinois law requiring health-maintenance organizations to submit to independent review of medical-necessity decisions when a primary-care physician and the HMO differ in their opinions is a statute that regulates insurance, thus falling outside the preemption provision contained in section 514(a) of the Employee Retirement Income Security Act of 1974.[4]

Though the *Moran* majority did not cite this Court's recent opinion in *Pegram v. Herdrich*, 530 U.S. 211, 120 S. Ct. 2143, 147 L. Ed. 2d 164 (2000),[5] the analysis contained in *Pegram* is helpful to the broad issue of whether and to what extent a state can lawfully regulate health-care matters without running afoul of ERISA preemption. *Amici* write

4. 29 U.S.C.A. § 1144(a). The Fifth Circuit reached a contrary result in *Corporate Health*.

5. The dissent in *Moran* believed that the panel opinion was "in tension with" *Pegram* and criticized the majority for failing to cite it. 230 F.3d at 974 (Posner, J., dissenting from denial of hearing *en banc*).

principally to discuss how *Pegram* and related authority support the *Moran* court's holding that ERISA does not preempt Illinois' independent-review statute,[6] though for somewhat different reasons.

Pegram held that HMO physicians making medical-necessity decisions are *not* making either fiduciary or administrative decisions, but are engaging in "mixed decisions" identical to those made by doctors in millions of other contexts—decisions that ERISA does not preempt. Because of the way that HMOs often define what they will and will not cover, by essentially entering the realm of medical-necessity decision-making, HMOs are engaging in the practice of medicine historically regulated by the states, a result neither intended nor supported by the legislative history either of ERISA or of the Federal HMO Act.

For these reasons, *amici* support the position of Respondents Debra C. Moran and the State of Illinois. Given the importance of the independent-review provisions to consumers, *amici* believes they can assist the Court in assessing whether ERISA preempts those provisions, and urge the Court to uphold the Seventh Circuit's opinion that it does not.

SUMMARY OF THE ARGUMENT

Amici anticipate that Respondents' briefs on the merits will thoroughly analyze and support the Seventh Circuit's conclusion that the "savings clause" found in ERISA section 514(b)(2)(A) applies to the independent-review provisions of the Illinois HMO Act. *Amici* will not duplicate those anticipated arguments, but write separately to emphasize two further reasons for upholding the appellate-court opinion in *Moran*. First, this Court's opinion in *Pegram v. Herdrich*

6. 215 ILL. COMP. STAT. 125/4-10 (West Supp. 2000).

signals broad acceptance of the idea that "mixed" eligibility and treatment decisions within an HMO structure implicate only state-law concerns and not ones covered by ERISA[7]—an idea that ought logically result in a holding that Illinois' independent-review legislation is also properly the province of state rather than federal law. Second, *Pegram*'s reliance, for part of its analysis, on the Health Maintenance Organization Act of 1973[8]—a statute predating ERISA by a year—makes useful an examination of the legislative history of that Act, for considering it in tandem with ERISA's purpose and intended scope yields further support for the validity of the Illinois legislation.

ARGUMENT

1. *Pegram v. Herdrich*: Congress did not intend for ERISA to preempt health-care issues, nor to set up a federalized system of treating medical-necessity determinations when made by an HMO.

Last year the Court held that mixed treatment and eligibility decisions made by an HMO, acting through its physicians, are not fiduciary acts under ERISA. *Pegram v. Herdrich*, 530 U.S. 211, 120 S. Ct. 2143, 147 L. Ed. 2d 164 (2000). Asked to hold that an HMO physician's delaying needed medical care to save money for the HMO and increase the physician's compensation breaches ERISA's fiduciary-duty provisions, the Court unanimously said no. Though *Pegram* did not involve whether ERISA preempts state legislation creating an independent body to review concurrent and prospective medical treatment and to opine on its necessity, the Court's reasoning is nonetheless instructive, and controlling here.

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7. Employee Retirement Income Security Act of 1974, 29 U.S.C.A. §§ 1001, *et seq.*

8. 42 U.S.C.A. § 300e, *et seq.*

Pegram is but the latest, in fact, of a line of cases in which this Court has noted that ERISA's preemptive reach was not so broad as earlier thought; beginning in 1995, the Court handed down a trilogy of cases reining in the notion that ERISA preempts any law that could be said to in any way "relate to" an employee-benefit plan. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995); *California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 117 S. Ct. 832 (1997); *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 117 S. Ct. 1747 (1997). Conversely, according to *Pegram*, recognizing an ERISA fiduciary-based remedy for what is essentially a state-law medical-malpractice claim would entail a federalized standard of reasonable medical care and "raise a puzzling issue of preemption":

> On its face, federal fiduciary law applying a malpractice standard would seem to be a prescription for preemption of state malpractice law, since the new ERISA cause of action would cover the subject of a state-law malpractice claim. See 29 U.S.C. § 1144 (preempting state laws that "relate to [an] employee benefit plan"). [*Pegram*, 120 S. Ct. at 2158.]

But noting that *Travelers* "throws some cold water on the preemption theory," the Court summed up that case's core holding: "[I]n the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose." *Id.*

And, importantly, the health-care issues before the Court in *Pegram* were ones found to be "inextricably mixed": administrative, coverage-type decisions (always preempted) and pure treatment decisions (the subject, most plainly, of state malpractice laws):

> It will help to keep two sorts of arguably administrative acts in mind. *Cf. Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 361 (C.A.3 1995) (discussing dual medical/administrative roles of HMOs). What we call pure "eligibility decisions" turn on the plan's coverage of a particular condition or medical procedure for its treatment. "Treatment decisions," by contrast, are choices about how to go about diagnosing and treating a patient's condition: given a patient's constellation of symptoms, what is the appropriate medical response? [*Id.* at 2153-54.]

The Court then concluded that Herdrich's complaint raised "just such mixed eligibility and treatment decisions," giving as examples

> physicians' conclusions about when to use diagnostic tests; about seeking consultations and making referrals to physicians and facilities other than [the HMO's]; about proper standards of care, the experimental character of a proposed course of treatment, the reasonableness of a certain treatment, and the emergency character of a medical condition. [*Id.* at 2155.]

Another way to phrase these types of decisions is, of course, that they are ones of "medical necessity," which are precisely what the Illinois HMO Act contemplated in establishing its independent-review scheme.

The next section of the *Pegram* decision signaled the end of ERISA preemption of mixed eligibility decisions—a category that naturally subsumes medical-necessity determinations—with Justice Souter opining that Congress "did not intend" for an HMO to be considered a fiduciary

"to the extent that it makes mixed eligibility decisions acting through its physicians. We begin with doubt that Congress would ever have thought of a mixed eligibility decision as fiduciary in nature." *Id.* Because those types of decisions are not fiduciary ones under ERISA, the Court's conclusion effectively ends ERISA preemption of state-law claims focused on an HMO's medical-necessity decisions, since they are by definition mixed eligibility ones.[9]

A finding of no fiduciary status with regard to medical-necessity decisions is tantamount to a broader finding that ERISA does not preempt other types of claims arising from such decisions (a question the Court has not faced until now): *Pegram*'s holding and reasoning, especially when coupled with this Court's recently developed and consistent view that Congress did not intend ERISA to preempt a subject of traditional state regulation such as health care, lead logically to just such a result.[10] Here, the Illinois legislation does

9. *Pegram* would also seem to implicitly disapprove the Fifth Circuit's earlier decision in *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321 (5th Cir. 1992), which held just such "mixed" decisions to be preempted. On petition for rehearing in *Corporate Health*, the Fifth Circuit rejected that view. 220 F.3d 641, 643-44 (5th Cir. 2000) ("[W]e do not read *Pegram* to entail that every conceivable state law claim survives preemption so long as it is based on a mixed question of eligibility and treatment, and *Corcoran* held otherwise." (Footnotes omitted.)).

10. Too, just one week after deciding *Pegram*, this Court denied an HMO's petition for writ of certiorari in *Bauman v. U.S. Healthcare, Inc.*, 193 F.3d 151 (3d Cir. 1999), *cert. denied*, 2000 U.S. Lexis 4177, 68 U.S.L.W. 3773 (June 19, 2000). In *Bauman*, the Third Circuit held that ERISA did not completely preempt the plaintiffs' claims that their HMO's failure to approve an in-home pediatric nurse visit led to their newborn daughter's death from an undiagnosed and untreated strep infection. "[I]t is the HMO's essentially medical determination of the appropriate level of care that the Baumans claim

(Cont'd)

nothing more than regulate the *quality* of medical care—the practice of medicine—by providing a mechanism for plan participants to obtain a medical "second opinion" about whether a particular course of treatment is indeed medically necessary. Because it implicates, at most, a mixed treatment issue, that legislation falls squarely within the ambit that Congress—and this Court—recognize as being reserved to the states.

The *Pegram* Court made it clear that mixed decisions are nothing more than medical-treatment decisions made "millions of times every day"[11] in other contexts, and that the decisions in those contexts are subject to state law. The most plausible conclusion to draw from *Pegram* is that even when an HMO arrogates to itself the "medical necessity" second-guessing function by the way that it writes its coverage agreement, the medical-necessity analysis by the HMO's medical director would not trigger preemption—and state law continues its vital role in regulating the HMO's health-care treatment decisions.

In short, given the development in caselaw from *Travelers* through *Pegram*, and the evolving refinements to preemption issues that this Court's decisions represent, the Seventh Circuit correctly held that ERISA does not preempt the independent-review feature of the Illinois HMO Act (though its holding was based on the savings clause rather

(Cont'd)
contributed to the death of their daughter. . . . Accordingly, the claim fits squarely within a class of claims that we identified in *Dukes* as involving the quality of care [and thus not preempted]." 193 F.3d at 163. Apparently rejecting the HMO's argument that the Baumans sought to recover for a denial of benefits—normally a preempted claim—this Court's denial of the petition for writ of certiorari shows that *Pegram*'s holding and reasoning are not limited to the narrow question of fiduciary status for a malfeasant HMO.

11. 120 S. Ct. at 2156.

than a finding that the legislation fell outside section 514(a)'s "relates to" language). And because at least forty-two states and the District of Columbia have either legislation or regulations establishing similar independent-review procedures, this is an issue of national importance.[12]

12. Rule 420-5-6.08, Alabama State Board of Health (1999); 2000 Alaska Sess. Laws 99; ARIZ. REV. STAT. § 20-2537 (West Supp. 1999); CAL. INS. CODE § 10169 (West Supp. 2000); COLO. REV. STAT. § 10-16-113.5 (West 1999); CONN. GEN. STAT. § 38a-478n (West Supp. 2000); DEL. CODE ANN. tit. 16, § 9119 (2000); D.C. CODE § 32-571.7 (Lexis Supp. 2000); 2000 Fla. Laws ch. 00-256 (West); GA. CODE ANN.§ 33-20A-32 (2000); 2000 Haw. Sess. Laws 250; 215 ILL. COMP. STAT. 125/4-10 (West Supp. 2000); IND. INS. CODE ANN. § 27-13-10.1-1 (West 2000); IOWA CODE ANN. § 514J (West 2000); KAN. STAT. ANN. § 40-22a13 (Supp. 1999); 2000 Kentucky Laws Reg. Sess. 262 (West); LA. REV. STAT. ANN. § 22:3081 (2000); 2000 Me. Legis. Serv. 742 (West); MD. CODE ANN. INS. §§ 15-10A through 15-10B (Lexis Supp. 1999); MASS. ANN. LAWS ch. 111, § 217 (West 2001); 2000 Mich. Legis. Serv. 251 (West); MINN. STAT. ANN. § 62Q.73 (West Supp. 2000); MO. REV. STAT. § 376.1385 (1997); MONT. CODE ANN. § 33-37-102 (1999); N.H. REV. STAT. ANN. 420-J:5 (2000); N.J. STAT. ANN. §§ 26:2S-11, 26:2S-12 (West Supp. 2000); N.M. ADM. CODE tit. 13, § 10.17.24 (Michie Supp. 2000); N.Y. INS. LAW § 4904 (McKinney 1999); N.C. GEN. STAT. §§ 58-50-61, 58-50-62 (1998); OHIO REV. CODE ANN. § 1751.84 (Baldwin Supp. 2000); OKLA. STAT. ANN. tit. 63, § 2528.3 (West 1999); 2001 Ore. HB 3040 (2001); 40 PA. CONS. STAT. § 991.2162 (1998); R.I. GEN. LAWS § 23-17.12-10 (Lexis Supp. 2000); 2000 S.C. Acts 380; TENN. CODE ANN. § 56-32-227 (West 1999); TEX. CIV. PRAC. & REM. CODE § 88.003 (2001); UTAH CODE ANN. § 31A-22-629 (2000); VT. STAT. ANN. tit. 8, § 4089f (1998); VA. CODE § 38.2-5900 to 38.2-5905 (Michie Supp. 2000); 2000 Wash. Legis. Serv. 5 (West); W. VA. CODE § 33-25C-6 (2001); 2000 Wisc. Legis. Serv. 155 (West).

2. The background and purpose of the 1973 Federal HMO Act show that Congress did not intend to remove medical-necessity issues from health-care providers—or from the states.

In addition to the aspects of *Pegram* discussed above, the Court also made explicit the usefulness of considering Congress's enactment of the Health Maintenance Organization Act of 1973 just one year before it enacted ERISA: in the Court's view, Congress could hardly have meant to encourage the formation of HMOs only to stifle them a year later by (if Herdrich's interpretation were accepted) including a fiduciary-duty standard in ERISA whose enforcement would entail "nothing less than elimination of the for-profit HMO." *Pegram*, 120 S. Ct. at 2156.[13]

While debate could be had on this latter conclusion (a debate not called for here), the pertinent point for the instant case is this: when considering whether Congress meant for ERISA to preempt state-law quality-of-care/ medical-necessity regulation of HMOs, such as Illinois' independent-review provisions, examining the preceding year's Federal HMO Act's legislative history is just as useful as examining that of ERISA itself. To *amici*'s knowledge, no case to date has done so, thus presenting the Court with

13. The *Pegram* Court noted that

> "for over 27 years the Congress of the United States has promoted the formation of HMO practices" and that federal courts would be "acting contrary to the congressional policy of allowing HMO organizations if it were to entertain an ERISA fiduciary claim portending wholesale attacks on existing HMOs solely because of their structure, untethered to claims of concrete harm."

120 S. Ct. at 2156-57.

an opportunity to delve more deeply into just how the two acts should be interpreted in tandem for preemption purposes.

Analysis of the Federal HMO Act—principally its 1973 legislative history and that of later specific amendments—shows that Congress intended the *states* to regulate HMO quality, including medical-necessity determinations, and never contemplated that HMOs would be able to arrogate to themselves the practice of medicine through a statute (ERISA) requiring almost unquestioning deference to a plan administrator's "benefit" decision. Stated another way, there is no demonstrable congressional intent to create, or even to show cognizance of, a process whereby *health plans* take from treating doctors, and the states, the determination of what care is appropriate, *i.e.*, medically necessary.

Several portions of the legislative history support *amici*'s view:

First, though Congress explored implementing a comprehensive federal regulation of HMO quality through a Commission on Quality Health Care Assurance,[14] it ultimately decided *not* to create such a commission, instead leaving quality-of-care regulation to the states.

But even when Congress was seriously contemplating regulating and overseeing HMO quality of care at the federal level, it recognized that some oversight and control by the states was appropriate. For example, in a separate section of the Senate Report, entitled "State Standards," the Committee on Labor and Public Welfare discussed the proposed Commission on Quality Health Care Assurance, making clear

14. Much of the 1973 Senate Report dealt with the proposed commission, but the actual HMO Act dropped it altogether when finally enacted. *See* S. REP. No. 93-129 (1973), *reprinted in* 1973 U.S.C.C.A.N. 3033.

that local (*i.e.*, state) concerns would govern health-care standards applicable to HMOs:

> [The Committee] is of the opinion that *the states*, through a designated state agency, *should be given the opportunity to develop health care standards* so that local and other variations can be taken into account though the Commission would have to assure itself that such standards would at least be as effective and rigorous as those the Commission itself would otherwise institute. The Commission is aware, for instance, that disease patterns and treatment methodologies do differ, and appropriately so, from state to state.[15]

And in the following paragraph, the Senate Committee stated:

> An added factor in this Committee's decision to *encourage states* to *develop their own standards* is the fact that experience in the medical care field has indicated that the closer the responsibility for standard development of health care regulation is to the actual provider of the care, the more likely the provider is to become involved in the development and setting of standards. The result is that these providers are more responsive to these standards when they have assisted in the development of the standards.[16]

As the Federal HMO Act was initially conceived, the Committee thus envisioned that each state should be given the opportunity to enforce its own promulgated HMO-quality

15. *Id.* at 3077 (emphasis added).

16. *Id.* (emphasis added).

standards, and nothing in the subsequent Conference Report or floor debate negates this clear congressional intent that (a) treating medical professionals, not HMOs, would determine "medical necessity"; and (b) the states would be responsible for administering HMO quality standards for health care, including "medical necessity."[17] And since Congress ultimately rejected establishing a federal commission that would have, to some extent, usurped state control, its intent is clear: quality-of-care issues—including those of medical necessity—were best left *entirely* to state control and regulation.

Elsewhere in the Senate Reports for the 1973 Act, it is apparent that the Committee on Labor and Public Welfare considered that the HMO structure would actually *remove* any financial incentives from the practice of medicine at the physician level, thereby—again—leaving medical-necessity determinations to the actual health-care providers and also, by logical extension, to the states, which were implicitly

17. It is on this point that *Corporate Health*'s inconsistency with respect to the state's right to regulate medical necessity decisions is revealed. On one hand, the Fifth Circuit states that a state licensing agency can enforce sanctions against a physician who acts on behalf of an HMO—for example, as medical director, in making medical necessity decisions. At the same time, however, the Court takes the inconsistent position that the state cannot regulate the very same decision-making in other contexts. *Corporate Health*, 215 F.3d at 534-35. This inconsistency fails to recognize and apply this Court's holding in *Pegram* which specifically states that HMO physicians making medical necessity decisions are *not* making ERISA administrative decisions, but are making just the sorts of "mixed medical decisions" made by "licensed medical practitioners millions of times every day, in every possible medical setting." *Pegram*, 120 S. Ct. at 2155-56. As a result, it is clear that the states have the right to create statutes, such as the IRO provisions at issue in both the *Moran* and *Corporate Health* matters, to ensure that these state quality-of-care standards are met by the HMO physicians who make medical necessity decisions.

(in the Act as enacted) given sole authority to regulate the field of health care:

> The medical group approach also provides opportunity for a restructuring of financial incentives. A health professional's income is not related directly to the number of services he provides, thereby removing a major incentive for over-utilization of services. In addition, it allows the *health professionals* to make judgments *based on medical necessity alone*.[18]

This language has never received substantial attention, especially in analyzing the interplay between the Federal HMO Act and ERISA, passed the very next year by the same Congress.[19] Though *Pegram* recognized the importance of the two acts adopted one year apart, that opinion did not explore the aforementioned actual legislative history. When that is done, it becomes inconceivable that with the Federal HMO Act Congress (a) meant to facilitate the removal of any financial incentives affecting medical-necessity determinations and to encourage "health professionals" and not HMOs to "make judgments based upon medical necessity alone," but (b) with ERISA, the very next year, it somehow intended to bestow on employee benefit plans, or on HMO providers contracting with ERISA plans, the ability to circumvent the prior year's intent that "*health professionals* [would make] judgments based on *medical necessity alone*." This conclusion is bolstered considerably by Congress's decision to leave all quality-of-care issues—including ones of medical necessity—to state control.

18. *Id.* at 3047 (emphasis added).

19. The Federal HMO Act and ERISA were passed during the first and second sessions, respectively, of the 93rd Congress.

Also noteworthy is that proposed section 1311(A) of the Federal HMO Act would have permitted a state agency or court to assert its jurisdiction under state law over any "health issue" not affected by standards or criteria promulgated under § 1302 of the Act.[20] The absence of any manifested intent even here to preempt state-law quality-of-care standards, and the eventual adoption of an Act that allows total state-law enforcement of health-care standards, effectively negates any argument that the Federal HMO Act began an attempt by Congress to allow federal preemption under the guise of either the HMO Act or ERISA, one year later, of state-law medical-necessity regulation.

And in the 1976 legislative session, just two years after enacting ERISA, Congress considered but rejected a federal-court remedy for enrollees of an HMO who were given assurances by an HMO, directly or indirectly, about basic and supplemental health services.[21] The conference substitute noted that rejecting the Senate's proposed federal remedy "[did] not change any existing right of individuals to bring suit in state courts."[22] This legislative history indicates that Congress did not intend to preempt even state-law fraud claims against HMOs, an intent evinced a mere two years after it enacted ERISA.

At bottom, it makes no sense to suppose that just one year after adopting the Federal HMO Act—which deliberately left regulation of HMO medical necessity decisions to the states—Congress intended through ERISA to supplant the

20. Section 1302 set forth the proposed functions of the (ultimately jettisoned) Commission.

21. H.R. Conf. Rep. No. 94-1513 (1976), *reprinted in* 1976 U.S.C.C.A.N. 4355, 4366.

22. *Id.*

states' ability to regulate the quality of medical necessity decisions that HMOs make. And nothing in ERISA's later development indicates any congressional intent, at any time, to override the clear intent contained in the HMO Act: that the states would be the ones to adopt and enforce HMO medical-care/health-care regulation.

Viewed in this light, the Illinois legislation simply fulfills what Congress envisioned when it decided to encourage the limited formation of HMOs some 27 years ago. What Congress gave the states with one hand—the ability to settle on appropriate quality-of-care standards—it did not take away with the other. As Justice Souter signaled in *Pegram*, it is wholly appropriate to consider the HMO Act when analyzing ERISA's preemptive effects on state laws that seek to establish the level of quality medical care that an HMO must provide. It would add considerably to the extant body of ERISA caselaw if this Court were to expound on the interplay between the two acts, especially given the large number of states that have enacted laws similar to the Illinois HMO Act.

3. ERISA's own legislative history negates any congressional intent to preempt state health-care-related claims.

Even without the Federal HMO Act's expressed preference for health-care/medical standards to be left up to the states, ERISA itself evinces no congressional intent to leave employees without any effective remedy for bad health-care-treatment or medical-necessity decisions. Indeed, quite the contrary.

First, the primary thrust of ERISA's protections involved *pension* plans.[23] This Court recognized that fact in *Pegram*,

23. *See, e.g.*, Jeffrey W. Stempel & Nadia von Magdenko, "Doctors, HMOs, ERISA, and the Public Interest after *Pegram v. Herdrich*," 36 TORT & INS. L.J. 687, 696 (Spring 2001) (hereafter "Stempel & Magdenko"), *quoting* 29 U.S.C. § 1001(a) itself, in which Congress declared that

> . . . despite the enormous growth in such plans many employees with long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans; that owing to the inadequacy of current minimum standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered; that owing to the termination of plans before requisite funds have been accumulated, employees and their beneficiaries have been deprived of anticipated benefits; and that it is therefore desirable . . . that minimum standards be provided assuring the equitable character of such plans and their financial soundness.

Stempel and Magdenko also note that "[a]lthough ERISA contains substantial codification of congressional findings regarding retirement benefits, the statute and legislative history are almost completely silent on the intent of Congress regarding other employer-provided fringe benefits." *Id.* at 697.

24. 530 U.S. at 232, 120 S. Ct. at 2156 (*citing* S. REP. No. 93-127, p. 5 (1973); S. REP. No. 93-383, p. 17 (1973); *id.* at 95)).

25. *Id.*

stating that congressional emphasis in drafting ERISA was on "fiduciaries' financial decisions, focusing on pension plans, the difficulty many retirees faced in getting the payments they expected, and the financial mismanagement that had too often deprived employees of their benefits."[24] As a result, according to *Pegram*, "it is at least questionable whether Congress would have had mixed eligibility decisions in mind when it provided that decisions administering a plan were fiduciary in nature."[25]

Beyond that, however, is the problem that ERISA's preemption clause was a last-minute addition to the legislation—and an addition not very well thought out at that.[26] As one commentator has noted, one of the few things that is clear about section 514's intent is that "to the extent Congress thought at all about preemption, 'section 514(a) was more in the nature of a quick statement of general principle than a workable, final rule.' "[27] As a result, "neither before nor after enactment of ERISA did Congress . . . view preemption policy issues as settled in the way that the sweeping statutory language of section 514 might suggest."[28]

That courts have consistently misinterpreted section 514—at least until the literalist tide turned with *Travelers*—is further shown when the final version of section 514, enacted with little comment, is compared with the versions originally proposed:

> As the Supreme Court has recognized, the versions of ERISA that worked their way through most of the legislative process tied the scope of preemption to the scope of ERISA regulation.

26. Catherine L. Fisk, "The Last Article About the Language of ERISA Preemption? A Case Study in the Failure of Textualism," 33 HARV. J. ON LEGISLATION 35, 53 (Winter 1996) (hereafter "Fisk") ("Although the legislative history of ERISA is voluminous [footnote omitted], it reveals that Congress gave little thought to preemption. Careful scholarship on the history of section 514 has shown that the exceptionally broad language 'was not a deeply considered result of the years of planning, negotiating, and drafting' that Congress put into ERISA [footnote omitted].")

27. Fisk at 55 (*quoting* Leon E. Irish & Harrison J. Cohen, "ERISA Preemption: Judicial Flexibility and Statutory Rigidity," 19 U. MICH. J.L. REF. 109, 114 (1985) ("Irish & Cohen")).

28. Irish & Cohen at 116.

[Footnote omitted] The House bill would have preempted state laws that "relate to the reporting and disclosure responsibilities and fiduciary responsibilities of persons acting on behalf of" ERISA-covered plans, and state laws that "relate to" funding and benefits-vesting provisions of pension plans. [Footnote omitted] The Senate version would have preempted state laws that "relate to the subject matters regulated by this Act." [Footnote omitted]

In the final joint conference on the bills, the Conference Committee abandoned these approaches and adopted the present language. When the Conference Committee Report was made available to the full Congress only ten days before the bill was enacted, little was said about the change. [Footnote omitted][29]

As Professor Fisk concludes, "[t]he change to section 514 is simply not evidence that Congress intended the enormously broad preemption, especially of laws remote from ERISA's purposes, that courts have created."[30]

And among those "remote" laws is of course state law dealing with the regulation of health care, as this Court has more than once pointed out.[31] Closely tied to such a "health care" exemption from ERISA's preemptive scope is the uselessness of "relate to" as a standard for preemption:

- "[A]pplying the 'relate to' provision according to its terms was a project doomed to failure, since, as

29. Fisk at 53.

30. *Id.* at 55.

31. *Dillingham*, 519 U.S. at 330; *De Buono*, 520 U.S. at 814; *Travelers*, 514 U.S. at 661.

many a curbstone philosopher has observed, everything is related to everything else. . . . The statutory text provides an illusory test, unless the Court is willing to decree a degree of pre-emption that no sensible person could have intended—which it is not."[32]

- Section 514's literal text could not be read to "extend to the furthest stretch of its indeterminacy, [or] for all practical purposes preemption would never run its course, for '[r]eally, universally, relations stop nowhere. . . .'"[33]

- "Our prior attempt to construe the phrase 'relate to' does not give us much help drawing the line here"; instead, the Court determined that it "must go beyond the unhelpful text . . . and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive."[34]

- "[T]his return [under the trilogy, to a traditional analysis of preemption] has included the observation that a broader reading of 'relates to' would sweep away common state action with indirect economic effects on the costs of health care plans, such as quality standards which may vary from state to state."[35]

32. *Dillingham*, 519 U.S. at 335-36 (Scalia, J., concurring).

33. *Travelers*, 514 U.S. at 655.

34. *Id.*

35. *Corporate Health*, 215 F.3d at 533. Notably, in his dissenting opinion Judge Posner focuses on the increased costs for ERISA plans (Cont'd)

To sum up, for the first two decades or so of ERISA's existence, courts applied an uncompromising analysis of preemption based on a literal reading of the text. But as both scholarship and recent caselaw has made clear, such a reading is unwarranted in light of ERISA's purpose and legislative history.

This conclusion is further warranted when this Court's recent and heightened scrutiny of congressional acts for some "national" importance is considered. For example, the Court invalidated the Gun-Free School Zones Act of 1990 in *United States v. Lopez*,[36] finding that Congress exceeded its authority under the Commerce Clause by criminalizing the possession of guns on school grounds: the Act neither regulated a commercial activity, nor did it contain a jurisdictional requirement that a particular instance of gun possession be linked to interstate commerce.

Most recently, the Court struck down the Violence Against Women Act,[37] holding that despite detailed findings

(Cont'd)
in offering health plans resulting from such independent review procedures. *Moran*, 230 F.3d at 973-74. As this Court held in *Travelers*, however,

> [T]o read the preemption provision as displacing all state laws affecting costs and charges on the theory that they indirectly relate to ERISA plans that purchase insurance policies or HMO memberships that would cover such services, would effectively read the limiting language in § 514(a) out of the statute, a conclusion that would violate basic principles of statutory interpretation.

Travelers, 514 U.S. at 661.

36. 514 U.S. 549 (1995).

37. *United States v. Morrison*, 529 U.S. 598, 120 S. Ct. 1740, 146 L. Ed. 2d 658 (2000).

in the congressional record about the economic impact of violence against women, the link between what has traditionally been a local concern and some effect on interstate commerce was too remote. In a passage reminiscent of its criticism of ERISA's "relate to" language,[38] the Court opined that Congress was relying on a "but-for casual chain from the initial occurrence of violent crime . . . to every attenuated effect upon interstate commerce."[39] Notably, the Court further observed that "[i]f accepted, [the Act's defenders'] reasoning would allow Congress to regulate any crime as long as the nationwide aggregated impact of that crime has substantial effects on employment, production, transit, or consumption."[40]

Although both *Lopez* and *Morrison* involved federal criminal statutes, the effect of this "new federalism" has not gone unnoticed.[41] And one point bears noting in light of the

38. *E.g., Travelers*, 514 U.S. at 655 ("[O]ne might be excused for wondering, at first blush, whether the words of limitation ('insofar as they . . . relate') do much limiting. If 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for '[r]eally, universally, relations stop nowhere,' H. James, Roderick Hudson xli (New York ed., World's Classics 1980).").

39. *Morrison*, 120 S. Ct. at 1752.

40. *Id.* at 1752-53.

41. *See, e.g.*, Erwin Chemerinsky, "Shrinking Federal Powers," 37 TRIAL 82, 83 (Jan. 2001) ("Many federal laws—for example, those adopted by Congress under the Commerce Clause—are sure to be objected to based on the narrow definition of Congress's power in *Morrison* and *Lopez*. . . . How far the Supreme Court will go in limiting congress's powers is uncertain. But it is clear from *Morrison* that five justices are committed to enforcing their vision of federalism and limiting the scope of federal authority."); A. Christopher Bryant (Cont'd)

Court's skepticism concerning even the most laudable congressional intent: Courts holding that ERISA preempts a claim against an HMO often rely on Congress's intent to create a uniform set of standards applicable to ERISA-related entities, thus (theoretically) avoiding the vagaries of fifty different sets of state laws. But "[d]espite the preemption language later in the statute [footnote omitted], ERISA's language and legislative history stress substantive remedies for workers more than the need for uniformity."[42] Notably, "[w]here uniformity is discussed, the implication is that uniformity and protection against state regulation are desired to prevent dilution of retirement benefits."[43] That "[n]o mention occurs of the possibility of preempting large blocks of state common law" is "unsurprising" given the statute's overall goal of protecting workers, and primarily their retirement benefits at that.[44]

(Cont'd)
& Timothy J. Simeone, "Remanding to Congress: The Supreme Court's New "On the Record" Constitutional Review of Federal Statutes," 86 CORNELL L. REV. 328, 395 (2001) ("In a series of recent cases, the Supreme Court has become increasingly aggressive in striking down federal statutes because Congress's formal legislative record inadequately supports factual findings or predictions underlying congressional action. In so doing, the Court has placed new procedural burdens on Congress to compile an extensive legislative record in support of statutes approaching the boundaries of the legislature's constitutional authority, much as federal agencies are required to compile a record in support of administrative action.")

42. Stempel & Magdenko, 36 TORT & INS. L.J. at 696.

43. *Id.* at 696-97.

44. *Id.* at 697 (*citing* H. REP. NOS. 93-533 and 93-807 (1973); SEN. REP. NOS. 93-127 and 93-383 (1973); H.R. CONF. REP. NO. 93-1280, *reprinted in* 1974 U.S.C.C.A.N. 4639 (1974); and numerous cases).

The illogic of making "uniformity" the sine qua non of ERISA preemption in the case of employee-welfare benefits as opposed to pension benefits is further shown by the fact that ERISA does not set out detailed requirements for the former, as it does with the latter. Sweeping preemption of state law makes more sense when Congress decides to regulate a field extensively, as it did with regard to pensions, but "broad preemption makes little sense when Congress does *not* extensively regulate in an area, as is the case with nonpension [e.g., health-care-related] benefits."[45]

In short, where no federal regulatory standards appear in ERISA, *and* where the HMO Act expressly left those standards to the states, preemption does nothing more than cast HMO members into a statutory abyss if legislation regulating medical-necessity decisions is found preempted.

At bottom, "uniformity" means nothing when ERISA says nothing about how patients' claims against their HMOs are to be handled—and the solution is not a blind adherence to a phantom notion of uniformity, but rather a recognition that Congress meant, as this Court has recognized, to allow states to continue their traditional role as the entity regulating the delivery of health care. Too, there are over one thousand HMOs operating in the United States, each with its own definition of "medical necessity." Were Congress as concerned about uniformity in the health-care field as some courts have opined, one would expect ERISA, or more appropriately the Federal HMO Act, to contain a uniform definition of when something is medically necessary. Neither act, of course, does.

---

45. Fisk, 33 HARV. J. LEG. at 56 (emphasis added) ("There is no evidence that Congress realized that broad preemption of state law would create a large regulatory vacuum with regard to nonpension benefits in particular. . . .").

Further, in practice the contrary view results in the *opposite* of uniformity: instead of a state (or even federal) standard of medical necessity, each HMO provides its own subjective determination of medical necessity for each given course of treatment, the result being that how a particular patient's condition is treated depends on the vagaries of which HMO he or she happens to be a member of—hardly a situation in which "uniformity" flourishes. The effect of ERISA preemption, therefore, is to subject employers and employees to over 1000 different standards of medical necessity (*i.e.*, the various managed care entities) compounded by thousands (*i.e.* the various medical directors, care managers and other employees') of standards of medical care, rather than one state standard.

If, then, Congress meant to invest ERISA with some uniform principles concerning medical necessity, thus justifying wholesale preemption of state health-care law, it failed miserably. Using "uniformity" as a means of rationalizing preemption is simply unworkable.

CONCLUSION

This case presents an important issue: Can a state lawfully adopt legislation ensuring that its citizens get medically necessary care from an HMO operating within that state's borders? Based on this Court's *Pegram* decision; on the legislative history of the 1973 HMO Act; and on ERISA's own legislative history, the answer is plainly yes. *Amici* respectfully urge this Court not only to affirm the Seventh Circuit's judgment for the reasons stated in *Moran*, but also to make clear that state independent-review legislation regulating HMOs' medical-necessity decisions do not even "relate to" ERISA plans in the first instance.

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BRIEF *AMICI CURIAE* OF AARP, NATIONAL EMPLOYMENT LAWYERS ASSOCIATION AND NATIONAL PARTNERSHIP FOR WOMEN & FAMILIES IN SUPPORT OF RESPONDENTS

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INTERESTS OF *AMICI CURIAE*[1/]

AARP is a nonprofit membership organization of more than 35 million persons, age 50 or older, working or retired, dedicated to addressing the needs and interests of older

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[1/] No counsel for any party authored any portion of this brief. No persons other than *amici curiae*, their members, or their counsel have made a monetary contribution to the preparation and submission of this brief. The written consents of the parties have been filed with the Clerk of the Court pursuant to Supreme Court Rule 37.3.

Americans. AARP seeks through education, advocacy and service to enhance the quality of life for all by promoting independence, dignity, and purpose. In its efforts to promote independence, AARP works to foster the health and economic security of individuals as they age by attempting to ensure the availability of quality and economical health coverage. As the country's largest membership organization, AARP has a long history of advocating for access to affordable health care and for controlling its costs without compromising quality. As additional means to foster the economic security of older individuals, AARP seeks to increase the availability, security, equity, and adequacy of public and private pension, health, disability, and other employee benefits.

The National Employment Lawyers Association (NELA) is a voluntary organization, founded in 1985, of more than 3,000 attorneys who specialize in representing individuals in controversies arising out of the workplace. It is the country's only professional membership organization comprised of lawyers who primarily represent employees in cases involving employment discrimination, employee benefits, wrongful discharge, and other employment-related matters. NELA has devoted itself to supporting precedent-setting litigation affecting the rights of individuals in the workplace.[2/]

The National Partnership for Women & Families is a national non-profit organization working to improve the lives of women and families through public advocacy, public education, and private partnerships. Founded in 1971 as the

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[2/] As part of their advocacy efforts to ensure, to the greatest extent possible, that participants and beneficiaries receive the benefits of ERISA's protections, AARP and NELA have participated as *amicus curiae*, both jointly and singly, in numerous cases involving ERISA's pre-emption clause, including *Egelhoff v. Egelhoff*, 532 U.S. 141, 121 S. Ct. 1322 (2001); *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358 (1999); *Boggs v. Boggs*, 520 U.S. 833 (1997); *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806 (1997); and *California Div. of Labor Stds. Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316 (1997).

Women's Legal Defense Fund, the National Partnership promotes equal opportunity for women, quality health care, and policies that help women and men meet both work and family responsibilities. The National Partnership has a longstanding history of defending the interests of women in the workplace and working to ensure that women have access to the benefits they need to support themselves and their families. The National Partnership firmly believes that strong and enforceable patient protections are an essential component of quality health care. As a result, the National Partnership has been a leading voice in promoting and defending meaningful patient protections for individuals in employer-sponsored health plans and public health programs.

Participants and beneficiaries in private, employer-sponsored employee benefit plans rely on the Employee Retirement Income Security Act (ERISA) to protect their rights under those plans. 29 U.S.C. § 1001 *et seq.* Contrary to ERISA's purpose, however, a statute that was designed to safeguard employee benefits has too frequently been used to deprive employees of rights and protections they previously enjoyed under state law. More recently, there have been attempts to use ERISA to undercut state attempts to regulate health care,[3/] even though the Court has recognized that such regulation is an area of traditional state concern. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, (*Travelers*) 514 U.S. 645, 654-55 (1995). Such court decisions bear directly on the ability of working Americans represented by AARP, NELA and the National Partnership to vindicate their claims for benefits as well as states' attempt to provide better consumer protections for their

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[3/] *Compare, e.g., Washington Physicians Serv. Ass'n v. Gregoire*, 147 F.3d 1039 (9th Cir. 1998), *cert. denied*, 525 U.S. 1141 (1999), *with Prudential Ins. Co. of Am. v. National Park Med. Ctr., Inc.*, 154 F.3d 812 (8th Cir. 1998). *See generally* Karen A. Jordan, *The Shifting Pre-emption Paradigm: Conceptual and Interpretive Issues*, 51 VAND. L. REV. 1149 (1998).

citizens.[4/] Thirty-nine states and the District of Columbia have implemented some form of independent review of health plan coverage decisions.[5/] In light of the significance of the issues presented by this case, AARP, NELA and the National Partnership for Women & Families respectfully submit this brief *amici curiae*.

SUMMARY OF ARGUMENT

ERISA's pre-emption clause states that it expressly pre-empts state laws that relate to an employee benefit plan and are not saved as a state law that regulates the business of insurance. ERISA §§ 514(a) & (b)(2). In its recent search to better define the parameters of the "relates to" portion of ERISA's pre-emption clause, the Court has often turned to traditional pre-emption concepts to help it. *Travelers*, 514 U.S. at 654-55; *California Division of Labor Standards Enforcement v. Dillingham Construction, N.A., Inc.*, 519 U.S. 316 (1997). Accordingly, the Court has adopted the presumption that the historic police powers of the States are not to be superseded by federal law unless Congress' intent to do so is clear. *Travelers*, 514 U.S. at 655, quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947). It has also recognized that the purpose of the Congress is the ultimate touchstone of pre-emption analysis. *Cipollone v. Liggett Group, Inc.*, 505 U.S. 504, 516 (1992). The Court has maintained Congress intended to pre-empt only state laws

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4/ Approximately two-thirds of Americans under the age of 65 are eligible for health benefits through employment-based health plans. *See* Paul Fronstin, Employee Benefit Research Inst., *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2000 Current Population Survey*, EBRI ISSUE BRIEF NO. 228 at 7 (Dec. 2000). In 1999, slightly more than one-quarter of retirees reported current coverage an employer-sponsored health plan. EBRI HEALTH BENEFITS DATABOOK at 68, tbl. 6.1 (1999).

5/ American Association of Health Plans, INDEPENDENT MEDICAL REVIEW OF HEALTH PLAN COVERAGE DECISIONS: EMPOWERING CONSUMERS WITH SOLUTIONS (April 2001).

which refer to or have a significant connection with an ERISA plan. *Dillingham*, 519 U.S. at 332.

Here the state of Illinois is regulating in an area of traditional state concern – health care, thereby raising the presumption against pre-emption which Petitioner has not overcome. The Illinois HMO Act neither refers to nor has a connection with an ERISA plan and hence does not relate to an ERISA plan for three reasons. First, the state law only regulates HMOs as service providers not as ERISA plans. *Washington Physicians Service Ass'n v. Gregoire*, 147 F.3d 1039, 1044-45 (9th Cir. 1998), *cert. denied*, 525 U.S. 1141 (1999); *see generally Dillingham*, 519 U.S. at 325-28. Second, the state law has no reference to an ERISA plan because although an ERISA plan could choose to use an HMO as a service provider there is nothing in the state law requiring the plan to do so. *Dillingham*, 519 U.S. at 325, 328. Third, the Illinois HMO Act also has no connection with an ERISA plan because it does not mandate employee benefit structures, and it does not bind employers or administrators to particular choices. Nor does it preclude uniform administration practices, provide alternative enforcement mechanisms or regulate a principal ERISA relationship. *Travelers*, 514 U.S. at 657-60; *Blue Cross of California v. Anesthesia Care Associates Medical Group, Inc.*, 187 F.3d 1045 (9th Cir. 1999); *Custer v. Sweeney*, 89 F.3d 1156 (4th Cir. 1996). The Illinois HMO Act does not mandate the distribution, payment or receipt of benefits. Instead it is limited to a process for determining appropriate medical treatment, an area of traditional state concern, which this Court has recently recognized is not pre-empted. *Pegram v. Herdrich*, 530 U.S. 211 (2000). Moreover, by its plain language, this Act provides the insured with no right to initiate the process, no right to appeal the plan's denial of the benefit, and no right to obtain benefits from the plan. This is not an alternative enforcement mechanism. Indeed, all this state law does is to provide a mechanism for handling disputes between physicians and HMOs, clearly not a regulation of a principal ERISA relationship. *Blue Cross*, 187 F.3d 1045, 1054; *Custer*, 89 F.3d 1156, 1167.

However, assuming for the sake of argument that the Illinois HMO Act did relate to an ERISA plan, not only would the Act be saved as a state law regulating the business of insurance,[6/] but there is no conflict with any ERISA remedy. *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987). Under the Court's conflict analysis, a state law is only in conflict with a federal law if compliance with both laws is a physical impossibility, which is not the case here, and if the state law stands as an obstacle to the objective of Congress in its enactment of ERISA. *John Hancock Mutual Life Insurance Co. v. Harris Trust & Saving Bank*, 510 U.S. 86 (1993). Here, the state law complements the federal law by providing a process to ensure full and fair review not by providing a new remedy. Indeed, the Court has never recognized a process, including arbitration, as a remedy in and of itself. Instead, in order to accept Petitioner's argument, the Court must decide to extend its finding in *Pilot Life* that ERISA prohibits any remedy in addition to those specifically enumerated in its civil enforcement provisions under § 502(a). Petitioner would also have the Court find that ERISA prohibits any process other than that enumerated in § 503.

In any event, given the Court's recent rulings on ERISA pre-emption, *Pilot Life* should be reexamined. Its statement that ERISA's civil enforcement provisions trump Congress' intent to maintain the states' power to regulate the business of insurance as explicitly stated in ERISA's saving clause should be repudiated. First, where Congress has expressly stated its intent to carve out certain areas of the law from the federal domain, the Court need not look to the statute as whole to deduce Congress' intent; Congress has already spoken. *Cipollone*, 505 U.S. 504. Second, the Court's reliance on LMRA § 301 is misplaced in that the statute has no carve out provision similar to ERISA's saving clause. Indeed, the Court's subsequent pre-emption decisions would counsel that

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6/ *Amici* do not address whether the Illinois HMO Act is a law regulating the business of insurance under the guidelines articulated in *UNUM v. Ward*.

an explicit pre-emption would not be overcome by an implied determination of Congressional intent. *Cipollone*, 505 U.S. at 516.

For all of these reasons, the Court should affirm the Seventh Circuit's decision that ERISA does not pre-empt the Illinois HMO Act.

ARGUMENT

I. ERISA DOES NOT PRE-EMPT THE ILLINOIS HMO ACT BECAUSE IT DOES NOT RELATE TO AN ERISA PLAN.

Amici contend that Petitioner has not overcome the presumption that ERISA does not pre-empt § 4-10 of the Illinois HMO Act -- a state law regulating health care.[7/] First, the Act does not regulate ERISA plans, but service providers to ERISA plans. Second, the Act does not reference ERISA plans; plans still may choose the method by which they provide benefits to their beneficiaries. Third, the Act does not have a significant connection with an ERISA plan because it does not fall within the three types of states laws that the Court has recognized will always have a connection with an ERISA plan -- those that mandate benefit structures or plan administration, those that bind employers or plan administrators to particular choices, and those that provide alternate enforcement mechanism. Finally, there is also no significant connection with an ERISA plan because the Act does not regulate a principal ERISA relationship.

7/ The statute provides in pertinent part:

Medical Necessity - Dispute Resolution- Independent Second Opinion. Each Health Maintenance Organization shall provide a mechanism for the timely review by a physician . . . who is unaffiliated with the Health Maintenance Organization, . . .in the event of a dispute between the primary care physician and the Health Maintenance Organization regarding the medical necessity of a covered service proposed by a primary care physician. 215 ILL. COMP. STAT. § 125/4-10 (2001).

A. The Presumption Against Pre-emption Applies to the Illinois HMO Act Because It Regulates Health Care -- an Area of Traditional State Concern.

When Congress passed ERISA, it limited a State's power to regulate only to the extent that its laws relate to employee benefit plans. ERISA § 514(a), 29 U.S.C. § 1144(a).[3] In its search to better define the parameters of the "relates to" portion of ERISA's pre-emption clause, the Court has recently turned to traditional pre-emption concepts to assist in its analysis. In *Travelers*, the Court specifically adopted the *Rice* presumption that ERISA should not pre-empt state laws unless it is clear that Congress intended to do so. 514 U.S. at 654-55, quoting *Rice*, 331 U.S. at 230 (consideration of whether a federal law pre-empts state law starts with "the assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress."). "Accordingly, the purpose of Congress is the ultimate touchstone of pre-emption analysis." *Cipollone*, 505 U.S. at 516; *see* U.S. CONST. art. VI, cl. 2. *Dillingham* reaffirmed this statement in *Cipollone* by holding that there must be an "indication in ERISA . . . [or] its legislative history of any intent on the part of Congress to pre-empt" a traditionally state-regulated area of law. 519 U.S. at 331.

Dillingham held that a state law only "relates to" an ERISA plan if it refers to or has a significant connection with an ERISA plan. In order for a state law to reference an ERISA plan, the state law must act immediately and exclusively upon an ERISA plan, or the existence of an ERISA plan is essential to the law's operation. *Id.* at 325. In order to determine whether the law has a significant connection to an ERISA plan, a court must examine ERISA's objectives to determine whether the type of state law at issue is one that Congress would not have intended to pre-empt and

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[3] ERISA § 514(a) states, in pertinent part, that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan."

then analyze the effect the state law has on ERISA plans. *Id.* at 332. "[I]f ERISA were concerned with any state action--such as medical-care quality standards or hospital workplace regulations--that increased costs of providing certain benefits, and thereby potentially affected the choices made by ERISA plans, we could scarcely see the end of ERISA's pre-emptive reach." *Id.* at 329; *accord*, *Egelhoff v. Egelhoff*, 532 U.S. 141, 121 S. Ct. 1322, 1327 (2001).

The Court's more recent analysis of ERISA pre-emption cases demonstrates a conscientious application of this presumption so that state laws only relate to an employee benefit plan, and therefore are pre-empted, if they truly impact ERISA's core concerns. *Compare Egelhoff*, 121 S. Ct. 1322 (state law governing the payment of benefits is pre-empted) and *Boggs v. Boggs*, 520 U.S. 833 (1997) (state law governing entitlement to benefits is pre-empted), *with De Buono v. NYSA-ILA Medical & Clinical Services Fund*, 520 U.S. 806 (1997) (state tax on gross receipts with minimal impact on plan administration is not pre-empted), and *Dillingham*, 519 U.S. 316 (prevailing wage statute posed no requirement on ERISA plans and is not pre-empted). Because health plans were not a focus of Congress' concern during the enactment of ERISA, ABA Section of Labor and Employment Law, EMPLOYEE BENEFITS LAW lxviii-lxix (2d ed. 2000), and health issues are a traditional area of state concern, *Travelers*, 514 U.S. at 654-55, generally state health laws are not pre-empted.

ERISA's pre-emption clause simply does not reach the Illinois' HMO Act provisions at issue because the state law merely requires HMOs to obtain independent second opinions when there is a dispute between its medical necessity decisions and those of treating physicians operating within their network. The Illinois law functions to regulate health care – a traditional area of state power which Congress did not intend to limit when it enacted ERISA. *Travelers*, 514 U.S. at 654-55.

B. The Illinois HMO Act Regulates HMOs as Medical Service Providers, Not as ERISA Plans.

ERISA will pre-empt a state law only if it relates to an ERISA plan. If an ERISA plan is not involved, there can be no ERISA pre-emption. *Cf. Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987) (where there is no ongoing administration such as in a one-time severance benefit there was no "plan" and the state law was not pre-empted). Thus, as the Court has recognized, it is imperative to determine whether the entity asserting ERISA's pre-emptive shield is an ERISA plan. *See, e.g., Pegram*, 530 U.S. at 223, 227.

When an employer establishes an employee health benefits plan, there are a variety of ways it can structure the provision of those benefits to employees. Employers may implement a plan through the purchase of insurance, self-funding, and/or the use of service providers such as managed health care organizations like HMOs or preferred provider organizations (PPOs). Simply because an ERISA plan purchases the services of an HMO does not mean that the HMO becomes the ERISA plan; such a finding would allow ERISA's pre-emption provisions to insulate the HMO from all state regulation. *See Pegram*, 530 U.S. at 223, 227 (documents establishing the HMOs do not establish an ERISA plan; "the HMO is not the ERISA plan").

Consistent with this distinction as articulated in *Pegram*, *Gregoire* recognized the difference between an ERISA plan and a service provider to that plan. The court found that a state's alternative provider statute did not have a significant connection with an ERISA plan because the statute required action solely by health providers; it did not require an ERISA plan to do anything. The statute only regulated and mandated benefits provided by insurers. The "mere fact that the Act regulates a product that ERISA plans often choose to buy does not mean that it 'relates to' an ERISA plan." 147 F.3d at 1045. *See generally Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 728-29 (1985) (states may require insurers to offer mental health benefits).

Here, the state of Illinois has decided that HMOs must provide for a second opinion if the primary care physician and HMO disagree over whether a particular procedure is medically necessary. The state law does not require the ERISA plan to do anything "It is merely one of many state laws that regulates one of many products that an employee benefit plan might choose to buy." *Gregoire*, 147 F.3d at 1044-45. Indeed, this is no different than the situation in *Dillingham*. Although an ERISA plan could have been used as a vehicle for paying prevailing wages to apprentices, there was nothing in California's prevailing wage statute that required the employer to do so. Thus the Court held that ERISA did not pre-empt the state prevailing wage law. *Dillingham*, 519 U.S. at 325-28. While the Illinois HMO Act regulates Rush-Prudential as the provider of medical services, the mere fact that Rush-Prudential provides those services to the beneficiaries of an ERISA plan does not mean the HMO's Act relates to an ERISA plan. On this basis alone, ERISA does not pre-empt the Illinois HMO Act.

C. The Illinois HMO Act Has No Reference To ERISA Plans Because It Does Not Require Plans or Administrators to Use HMOs as Medical Service Providers.

In *Dillingham*, the Court held that in order for a state law to reference an ERISA plan, the state law must act immediately and exclusively upon an ERISA plan or the existence of an ERISA plan is essential to the law's operation. In *Dillingham*, the Court declined to find that the state prevailing wage law made a reference to ERISA plans. The Court based its decision on the fact that apprenticeship programs need not necessarily be ERISA plans, and the employer could pay apprentices out of its general assets. The Court found that the prevailing wage law functioned regardless of whether an ERISA plan existed. 519 U.S. at 325.

The Illinois HMO Act is no different than the prevailing wage law in *Dillingham*. The Illinois HMO Act functions only where an HMO is involved. The HMO Act functions regardless of the entity (e.g., an individual, a church plan, a governmental plan) which purchases the services of an HMO as a medical service provider. The HMO Act functions irrespective of whether an ERISA plan uses an HMO as a medical service provider. It makes no reference to ERISA plans, and is not pre-empted on that basis. *See id.* at 328.

D. The Illinois HMO Act Does Not Have A Significant Connection With ERISA Plans.

1. The Illinois HMO Act does not mandate employee benefit structures, bind employers or administrators to particular choices, preclude uniform administrative practices, or provide alternate enforcement mechanisms to obtain benefits.

In *Travelers*, the Court recognized that three types of state laws will always be pre-empted: (1) state laws that mandate employee benefit structures or their administration; (2) state laws that bind employers or plan administrators to particular choices or preclude uniform administrative practice, thereby functioning as regulations of ERISA plans themselves; and (3) state laws providing alternate enforcement mechanisms for employees to obtain ERISA plan benefits. These types of state laws are certainly within the field that Congress intended to occupy when it enacted ERISA and will always have a connection to an ERISA plan. *See Travelers*, 514 U.S. at 657-60.

Since *Travelers*, the Court has attempted to provide guidance on the types of laws that fall into these categories. State laws that interfere with ERISA's distribution of benefits scheme or a plan's administrative functions have been pre-empted. *See, e.g., Egelhoff*, 121 S. Ct. at 1327; *UNUM Life Insurance Co. of America v. Ward*, 526 U.S. 358, 378-79 (1999); *Boggs*, 520 U.S 833. In contrast, where the state statute merely alters the economic incentives involved, ERISA

does not pre-empt the state law. *See, e.g., De Buono*, 520 U.S. at 815; *Dillingham*, 519 U.S. at 334.

The Illinois HMO Act does not mandate benefit structures or their administration because it does not address who will receive benefits, the kind of benefits to be paid, or how those benefits will be paid. *Compare Egelhoff*, 121 S. Ct. 1322 (2001); *Boggs*, 520 U.S. 833 (1997); *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985).

The Illinois HMO Act does not bind the employer or the plan administrator to any particular choice concerning benefits or administrative practices. For an ERISA plan, the Illinois Act only is triggered if it employs an HMO as a provider of medical services. The plan has a choice in choosing its provider of medical services. *Dillingham*, 519 U.S. at 325. The Illinois Act does not bind the plan to any choices concerning the provision of medical provider. The Act assumes that the plan covers the medical treatment if the HMO and the primary care physician agree that the treatment is medically necessary. Instead, this statute is limited to providing a process solely for determining appropriate medical treatment, an area of traditional state concern. The Court has recently recognized that decisions concerning medical necessity are not pre-empted because they are more akin to medical treatment decisions. *See Pegram*, 530 U.S. 211 (in *dicta*, mixed benefit eligibility and treatment decisions are not pre-empted); *Travelers*, 514 U.S. at 654-55. Thus, the Illinois HMO Act does not bind the employer or plan administrator to any particular choices concerning benefits.

Moreover, nothing in this Act dictates procedures to guide processing of claims and disbursement of benefits. *Egelhoff*, 121 S. Ct. at 1328 (quoting *Fort Halifax*, 482 U.S. at 9). Unlike the statutes involved in *Egelhoff* and *Boggs*, the HMO Act has nothing to do with the disbursement of benefits. The Illinois HMO Act does not dictate the payment of plan benefits. The Illinois HMO Act neither binds employers or plan administrators to particular choices concerning benefits or precludes uniform administrative practice. However, it does bind the HMO as medical service provider. "In the

event that the reviewing physician determines the covered service to be medically necessary, the Health Maintenance organization shall provided covered service." 215 ILL. COMP. STAT. § 125/4-10 (2001). It is a matter of contract and negotiation between the HMO and the plan whether, and how, to fund the requested service, but the HMO Act does not control that relationship.

Finally, this Act does not provide an alternate enforcement mechanism for a participant to obtain ERISA benefits. Under the Act, although the participant may file a complaint with the Insurance Commissioner if the HMO is not in compliance with the Act, the statute provides only that the Commissioner may act on the complaint by investigating the HMO and taking appropriate action such as levying fines and penalties.[2/] 215 ILL. COMP. STAT. § 134/105 (2001). Under the Illinois HMO Act, the participant has no right to initiate the second opinion process, has no right to appeal a denial of benefits and has no right to obtain benefits. 215 ILL. COMP. STAT. § 125/4-10 (2001). Indeed, the statute only applies when a physician disagrees with the HMOs determination that the requested services are not medically necessary. *Cf. Corporate Health v. Texas Dep't of Ins.*, 220 F.3d 641, 644-45 (5th Cir. 2000) (where patients can appeal "adverse determination" of managed care entities as to coverage, Texas IRO provisions created an alternative enforcement mechanism). In Illinois, the participants' only option in the face of the HMO's continued refusal to provide the services is to file a benefit claim under the plan's benefit claim process and/or sue under ERISA's civil enforcement procedures. By the plain language of its terms, § 4-10 of the Illinois HMO Act does not provide an alternative enforcement mechanism.

Accordingly, unlike the state statute at issue in *Egelhoff*, the Illinois HMO Act does not "implicate[] an area of core

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[2/] Investigation by the state insurance commissioner for violation of state insurance laws is a classic insurance examination process. *E.g.*, Peter M. Lencsis, INSURANCE REGULATION IN THE UNITED STATES: AN OVERVIEW FOR BUSINESS AND GOVERNMENT 31, 106 (1997).

ERISA concern," *Egelhoff*, 121 S. Ct. at 1327, and thus does not fall into any of the three categories of state laws that the Court has recognized will always have a connection with an ERISA plan. Hence, the Act does not relate to an ERISA plan and is not pre-empted.

2. The Illinois HMO Act does not have a significant connection with ERISA plans because there is no clear manifestation of Congressional intent to pre-empt laws concerning the relationship between physicians and service providers to ERISA plans.

In *Dillingham*, the Court held that there must be an "indication in ERISA . . . [or] its legislative history of any intent on the part of Congress to pre-empt" a traditionally state-regulated area of law. 516 U.S. at 331. Health care, and particularly physician relationships involving quality of medical care, is a traditional area of state regulation. *See Pegram*, 530 U.S. at 237 (refusal to federalize medical malpractice suits); *Travelers*, 514 U.S. at 654-55.

Nothing in ERISA or its legislative history evinces a clear legislative intent to pre-empt traditional state laws that do not affect the relations among the principal ERISA entities – the employer, the plan fiduciaries, the plan, and the beneficiaries. *See, e.g., Blue Cross of California v. Anesthesia Care Associates Medical Group, Inc.*, 187 F.3d at 1054; *Arizona State Carpenters Pension Trust Fund v. Citibank*, 125 F.3d 715, 724 (9th Cir. 1997); *Custer*, 89 F.3d at 1167. When a state law does not regulate an ERISA-governed relationship, it will not be pre-empted. *See id.*; *Hospice of Metro Denver, Inc. v. Group Health Insurance of Oklahoma, Inc.*, 944 F.2d 752, 756 (10th Cir. 1991) (law affecting the relations between an ERISA entity and an outside party is not pre-empted). Quite simply, if there is no regulation of an ERISA-governed relationship, more likely than not, there will be no significant effect on the structure, administration, or the type of benefits provided by the plan. *Id.*

Here, the Illinois HMO Act regulates only the relationship between the primary care physician and the HMO. Nothing in ERISA or its legislative history indicates any intent to regulate the relationship between a medical service provider and its doctors. Indeed, the Court has refused to read any Congressional intent to regulate doctors as doctors into ERISA. *Cf. Pegram*, 530 U.S. at 237, citing *Travelers*, 514 U.S. at 654-55 (declining to turn a state cause of action for medical malpractice into an ERISA fiduciary claim).

The Court has acknowledged that a determination of medical necessity is, in part, a treatment decision, and, as such, is more closely aligned with state malpractice and quality of care claims rather than federal benefit eligibility claims. Such claims would not be pre-empted. *See Pegram*, 530 U.S. at 229, 237, citing *Travelers*, 514 U.S. at 654-55; *Bauman v. U.S. Healthcare, Inc.*, 193 F.3d 151, 162 (3d Cir. 1999), *cert. denied*, 530 U.S. 1242 (2000) ("when the HMO acts under the ERISA plan as a health care provider, it arranges and provides medical treatment, directly or though contracts with hospitals, doctors, or nurses. . . . In performing these activities, the HMO is . . . subject to the prevailing state standard of care").

The Illinois HMO Act provides procedures to resolve disputes concerning appropriate medical treatment decisions. Because the state law here concerns disputes over medical treatment decisions, not benefit eligibility, it is within the states' purview to regulate such disputes without interference from ERISA.

II. ERISA DOES NOT PRE-EMPT § 4-10 OF THE ILLINOIS HMO ACT BECAUSE THERE ARE NO IRRECONCILABLE CONFLICTS WITH ERISA.

In previous decisions, the Court has recognized the possibility of dual federal and state regulation of ERISA plans. *See, e.g., Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (states may mandate benefits in insured ERISA plans). In *John Hancock*, the Court

recognized that "ERISA leaves room for complementary or dual federal and state regulation[.]" 510 U.S. at 98. Significantly, the Court held that generally state law governing insurance is not displaced. Federal pre-emption of state insurance regulation would only occur "'where compliance with both federal and state regulations is a physical impossibility,'" *Boggs*, 520 U.S. at 844 (quoting *Gade v. National Solid Wastes Management Ass'n*, 505 U.S. 88, 98 (1992)), or "'where [that] law stands as an obstacle to the accomplishment of the full purposes and objectives of Congress[.]'" *John Hancock*, 510 U.S. at 99 (first alteration in original) (quoting *Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238, 248 (1984)). In *John Hancock*, the Court "call[ed] for federal supremacy [only] when the two regimes cannot be harmonized or accommodated." *Id.* at 98. In essence, the Court construed ERISA to set minimum standards which insurance laws can complement or supplement.

Analysis of recent ERISA pre-emption case law shows that compliance with the requirements of both the Illinois HMO Act and ERISA can be harmonized or accommodated. Here, compliance with both laws is physically possible and the HMO Act does not stand as an obstacle to the accomplishment of the full purposes and objectives of Congress. We address each prong of this analysis.

A. A Plan Can Comply with Both the Illinois HMO Act And ERISA Because There Are No Irreconcilable Conflicts.

Recent cases illustrate the high burden which must be met in order for the Court to find that compliance with both federal and state laws is a physical impossibility. In *John Hancock*, the Court rejected the argument that ERISA and state insurance laws were at odds and "would pose irreconcilable conflicts between state and federal regulatory schemes" concerning the regulation of insurance general account contracts. 510 U.S. at 97. The Court did not find that ERISA's fiduciary requirement to act solely in the interest of participants and state insurance requirements to consider the interests of all its contract holders, creditors and

shareholders were in conflict, but rather these requirements could exist as dual federal and state regulation. *Id.* at 97-98.

Subsequently, in *UNUM v. Ward*, 526 U.S. at 374-77, the Court rejected UNUM's argument that California's notice-prejudice rule conflicts with the substantive provisions of ERISA. The Court held that states have the power to alter the terms of the insurance relationship because to hold otherwise would read the saving clause out of ERISA and create a unintended conflict with ERISA's fiduciary requirement of acting in accordance with the plan documents. The Court's reasoning in *UNUM* is also valid in this case. In *UNUM*, the Court summarily rejected the argument that there is a conflict with the civil enforcement provisions since, as in this case, Mr. Ward had to sue under § 502(a) in order to recover his benefits. Finally, the Court held that the state law, by allowing a longer period to file rather than ERISA's minimum time, complemented ERISA. Here, the Illinois HMO Act merely provides full and fair review in the administrative hearing process.

Indeed, all the Illinois HMO Act does is to provide a constructive mechanism to manage disputes over medical treatment between physicians and the HMOs with which they are affiliated. If an insured disagrees with a determination of medical necessity of either the treating physician or the HMO or the HMO decides not to follow the second opinion, as in this case, the insured's only recourse in the face of a continued denial is to follow the ERISA claim procedures, and if necessary, file suit under ERISA § 502(a), 29 U.S.C. § 1132(a). The Illinois HMO Act complements ERISA's enforcement scheme. It does not provide any additional remedies beyond those which ERISA provides.

Because an HMO can physically comply with both the Illinois' HMO Act and ERISA, there is no irreconcilable conflict between these two laws.

B. The Illinois HMO Act Does Not Stand as an Obstacle to The Accomplishment and Execution of the Full Purposes and Objectives of Congress in its Enactment of ERISA.

The "stands as an obstacle" prong for determining whether there is a conflict between state and federal law requires the Court to determine the intent of Congress and the determination whether Congress intended to occupy the field. Paul Wolfson, *Pre-emption and Federalism: The Missing Link*, 16 HASTINGS CONST. L.Q. 69 (1988). Because Congress specifically ceded power back to the states to regulate the business of insurance in § 514(b), the entity arguing that there is a conflict between ERISA and state insurance law has a high burden to show the state insurance law cannot be harmonized and accommodated with ERISA. *John Hancock*, 510 U.S. at 97-98.

> Analysis of whether a state law frustrates the attainment of Congress' objectives involves several steps: an identification of congressional purposes; an assessment of the effect of the state law; and a determination whether that effect "stands as an obstacle" to one of the purposes underlying the federal law.

Karen A. Jordan, *The Shifting Pre-emption Paradigm: Conceptual and Interpretive Issues*, 51 VAND. L. REV. 1149, 1200 (1998).

ERISA's declared principal purpose is "to protect plan participants and beneficiaries." *Boggs*, 520 U.S. at 845 (citing *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983)); ERISA § 2(b), 29 U.S.C. § 1001(b). Among the ways participants and beneficiaries are to be protected is by providing for "appropriate remedies, sanctions and ready access to Federal courts." ERISA § 2(b), 29 U.S.C. § 1001(b). In this instance, as in *UNUM v. Ward*, state insurance laws may set standards in addition to ERISA's minimum standards so as to better protect insureds. Merely because federal and state laws are different does not mean that

there is an impermissible conflict. ERISA is not absolute, but explicitly recognizes a role for state insurance regulation, thus permitting state insurance laws to supplement or complement ERISA's standards. *John Hancock*, 510 U.S. at 97-98; *cf. Wisconsin Public Intervenor v. Mortier*, 501 U.S. 597 (1991) (federal law set the minimum standard for pesticide use, and thus did not pre-empt local rules); *Florida Lime & Avocado Growers, Inc. v. Paul*, 373 U.S. 132 (1963) (federal law did not pre-empt state law setting other standards for measuring the maturity of avocados).

This analysis is consistent with the Court's decisions in *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), and *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985). In *Metropolitan Life Insurance*, the Court held that ERISA did not pre-empt a state law mandating minimum mental health benefits because it was exempted under the saving clause. *Id.* at 744. The Court did not find that state laws regulating the substantive terms of group health insurance contracts conflict with ERISA. Similarly, in *FMC Corp.*, the Court held that a state anti-subrogation clause was pre-empted as applied to a self-funded ERISA plan. The Court emphatically stated:

> [I]f a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer's insurance contracts; if the plan is uninsured, the State may not regulate it. As a result, employers will not face "conflicting or inconsistent State and local regulation of employee benefit plans."

FMC Corp., 498 U.S. at 64 (quoting *Shaw*, 463 U.S. at 99). Thus, the Court implicitly found that state insurance regulation did not lead to conflict or inconsistency with ERISA.

Petitioner analogizes the Illinois HMO Act to arbitration. This analogy fails for two reasons. First, insureds have no right to initiate the non-binding second opinion process; clearly this is contrary to binding arbitration. Second, even

if the process is binding, insureds do not obtain the remedy they are seeking -- their benefits.

When the Court has discussed "remedies," and whether ERISA provides for certain remedies, it has done so using the common sense meaning of the word. Thus, the Court has defined remedies as injunctions, payment of money, writs of mandamus, damages, specific performance, restitution, and extra contractual remedies. *See generally Harris Trust & Savings Bank v. Salomon Smith Barney Inc.*, 530 U.S. 238 (2000) (permitting restitution); *Mertens v. Hewitt Associates*, 508 U.S. 248, 256-58 (1993) (equitable relief); *Massachusetts Mutual Life Insurance Co. v. Russell*, 473 U.S. 134, 144 (1985) (extra contractual damages).

Not surprisingly, the Court has never mentioned or considered non-binding arbitration as a remedy, in and of itself. Instead, it is a process or procedure to obtain a remedy, such as money or reinstatement. Even in binding arbitration, in order to enforce the arbitral award and obtain back pay for example, the winning party may still have to go to court under the relevant statute. *See, e.g., United Steelworkers v. Enterprise Wheel & Car Corp.*, 363 U.S. 593 (1960); *United Steelworkers v. Warrior & Gulf Navigation Co.*, 363 U.S. 574 (1960); *United Steelworkers v. American Manufacturing Co.*, 363 U.S. 564 (1960). Thus, Petitioner's analogy between § 4-10 of the Illinois HMO Act and arbitration is instructive because like arbitration, in order to obtain the available remedy -- benefits, the participant must still sue under ERISA's civil enforcement provisions. It is not the process or the procedure, which is the remedy - it is the benefit which is the remedy.

Petitioner's real complaint is that § 4-10 of the Illinois HMO Act may have some impact on the ultimate result in the benefits claims process. In a lawsuit under ERISA § 502(a)(1)(B) - the insureds' only method of obtaining their benefits - it is probable that a court will look at the second reviewer's decision in determining whether the plan properly withheld benefits under the appropriate standard of review. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101

(1989). Thus, for example, if the plan refuses to provide the benefit to the participant after the second opinion, and the participant sues for benefits, the plan's denial of benefits might be reviewed under the arbitrary and capricious standard. Petitioner may anticipate that it will be harder to prove that its actions were not arbitrary and capricious in its denial of the claim where both the primary care physician and an independent second opinion disagree with the HMO's decision. Indeed, the converse would also be true – it would be harder for the participant to show an abuse of discretion if the independent reviewer agrees with the HMO. In either event, such impact on the standard of review does not make the Illinois HMO Act a new remedy.

In essence, Petitioner espouses that ERISA's claims procedure under § 503 is exclusive of all other review procedures. Petitioner's analogy here to *Pilot Life*'s finding that the civil enforcement provisions of § 502(a) are exclusive fails. Because the Illinois HMO Act is consistent with ERISA's requirement of providing full and fair review under § 503, there is no conflict. Indeed, as in *John Hancock* and *UNUM*, the state law can be harmonized with ERISA. *See UNUM v. Ward*, 526 U.S. at 377; *John Hancock*, 510 U.S. at 97-98.

Under the Illinois statute, participants still have to file a benefits claim and file a lawsuit under ERISA's civil enforcement provisions if their benefits claim is denied. There is no conflict or inconsistency with ERISA. The Illinois HMO Act cannot be found to stand as an obstacle to the accomplishment and execution of Congressional purposes and objectives. Instead, this law can easily be harmonized or accommodated with ERISA and should not be pre-empted.

III. BECAUSE CONGRESS EXPRESSLY INDICATED ITS INTENT THAT STATE LAWS REGULATING INSURANCE ARE OUTSIDE THE FIELD OF ERISA PRE-EMPTION, *PILOT LIFE* INCORRECTLY FOUND THAT THE SCOPE OF ERISA'S SAVING CLAUSE WAS LIMITED BY REFERENCE TO ERISA'S CIVIL ENFORCEMENT MECHANISMS.

When Congress enacted ERISA's pre-emption clause, it expressly demarcated which laws would not be pre-empted. Congress explicitly and clearly stated that states would retain the power to regulate insurance even where state insurance laws applied to employee benefit plans.[10/] ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A).[11/] Significantly, the Court has recognized Congress' intent to circumscribe the field of ERISA pre-emption by ceding power back to the states to regulate insurers and has interpreted this provision to give effect to this intent. *See, e.g., UNUM v. Ward*, 526 U.S. 358; *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. at 728-29.

The Court has recognized that field pre-emption may be found if state law regulates conduct in a field that Congress intended the federal government to occupy exclusively. Such intent may be inferred from a scheme of federal regulation so pervasive that Congress left no room for states to supplement it or where the act of Congress touches a field where the federal law is so dominant that the federal system will be assumed to preclude enforcement of state laws on the same subject. However, Congress' intent to do so must be clear

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10/ Although deciphering Congressional intent in ERISA's relate to clause may be difficult because the language of that clause is unhelpful, *see Travelers*, 514 U.S. at 656, the one clause in which Congressional intent is clearly stated is in the saving clause.

11/ ERISA § 514(b)(2)(A) states, in pertinent part, that: "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any States which regulates insurance . . . "

and manifest. *See Cipollone*, 505 U.S. at 516.

In *Cipollone,* the Court addressed the issue of the interrelationship between an express pre-emption clause, like the one at issue here, and implied field pre-emption. It held that:

> When Congress has considered the issue of pre-emption and has included in the enacted legislation a provision explicitly addressing that issue, and when that provision provides a "reliable indicium of congressional intent with respect to state authority," "there is no need to infer congressional intent to pre-empt state laws from the substantive provisions" of the legislation.

Cipollone, 505 U.S. at 517 (citations omitted). Accordingly, where Congress has enacted a provision expressly authorizing the states to retain their power to regulate in certain areas of law, it unequivocally establishes that such matters are not pre-empted. *Id.*

Contrary to these principles in *Cipollone*, the decision in *Pilot Life*, 481 U.S. at 52, ignored the saving clause, which showed Congress' manifest intent to maintain the states' authority to regulate the business of insurance. Instead, the Court looked at legislative history declaring that the pre-emptive force of ERISA § 502(a) was modeled on the exclusive remedy provided by the Labor Management Relations Act § 301, 29 U.S.C. § 185 (2001) ("LMRA"), and the language and structure of the civil enforcement provisions. It concluded that Congress intended that the civil enforcement provisions of ERISA § 502(a) were to be the exclusive vehicles for actions by insureds alleging improper processing of benefit claims. Accordingly, even if the state law was saved from pre-emption as a law regulating insurance, the Court would have found that the state law would still be pre-empted because it provided for remedies that ERISA does not provide. *Pilot Life*, 481 U.S. at 55.

Because ERISA's saving clause is explicit and there is no question of Congress' intent to permit the states to regulate the business of insurance, there was no need for the Court to look at anything but the plain language of the statute. It was unnecessary for the Court to continue its analysis. Moreover, not only do later cases call into question the underpinnings of the Court's decision, but the Court's conclusion does a disservice to the statute by not giving effect to Congress' intent.

In addition, even if the Court believed that it needed to further discern Congressional intent, the rationale of its decision missed the mark. Unlike ERISA, the Labor Management Relations Act does not have an express pre-emption clause, let alone a specific clause carving out certain areas of the law which are not pre-empted. Instead, the Court has implied field pre-emption from LMRA § 301 where the state law claim relies upon the analysis of the terms of the collective bargaining agreement. *See Allis-Chalmers Corp. v. Lueck*, 471 U.S. 202, 220 (1985). In discussing the pre-emptive force of § 301, the Court has found that Congress intended doctrines of federal labor law to prevail over inconsistent state rules. *See Teamsters v. Lucas Flour Co.*, 369 U.S. 95, 103-04 (1962). Indeed, finding that the enforcement mechanism of § 301 is exclusive is wholly consistent with field pre-emption principles – federal regulation of an area of law that is so pervasive that Congress left no room for states to supplement.

Assuming that a comparison between ERISA § 514(a) (ERISA's "relates to" clause) and LMRA § 301 is, in some sense, appropriate, as to the general scope of pre-emption, such comparison gives no guidance here because LMRA § 301 does not have a saving clause similar to ERISA § 514(b)(2)(A). Unlike the Congressional intent to cede power to the states to legislate in the business of insurance emphatically shown in ERISA's saving clause, the Court has never found Congressional intent to permit states to supplement federal power in the field of labor relations.

In *Franchise Tax Board of California v. Construction*

Laborers Vacation Trust Fund for Southern California, 463 U.S. 1 (1983), the Court explicitly recognized the difference between ERISA § 514 and LMRA § 301. The Court stated that "[Section 502(a)] does not purport to reach every question relating to plans covered by ERISA. Furthermore, § 514(b)(2)(A) of ERISA, 29 U.S.C. § 1144(b)(2)(A), makes clear that Congress did not intend to pre-empt entirely every state cause of action relating to such plans." *Id.* at 25. "In contrast, § 301(a) of the LMRA applies to all '[suits] for violations of contracts between an employer and a labor organization. . . .'" *Id.* at 25 n.28. The Court recognized that ERISA expressly permits states to regulate ERISA plans through certain mechanisms and thereby supplement federal law, while the LMRA has no such method for states to supplement federal law.

Section 514(b)(2)(A) of ERISA helps to define the field of ERISA pre-emption - state regulation of insurance is not within that field. Congress specifically permitted states to directly regulate the business of insurance and indirectly regulate ERISA plans that purchase services from insurers. Because ERISA's field of state laws that may be pre-empted does not include those regulating the business of insurance, ERISA's civil enforcement provisions are not the exclusive means of enforcement when it comes to insurers. As long as there is no direct conflict with ERISA, as *amici* have already demonstrated, the Illinois HMO law may act as a supplement to federal law. *See UNUM v. Ward*, 526 U.S. at 377; *John Hancock*, 510 U.S. at 98 (dual state and federal regulation of ERISA plans is permitted).

Not surprisingly then, the Court has found that state mandated benefits statutes imposing requirements on insurers as well as procedures for filing claims with insurers are saved from ERISA pre-emption. *See UNUM v. Ward*, 526 U.S. at 373-75 (1999); *Metropolitan Life Insurance Co. v. Massachusetts,* 471 U.S. at 742-45. Although the Court recognized that such an interpretation would result in "disuniformities currently facing national plans" entering local insurance markets, such disuniformities "are the inevitable result of the congressional decision to 'save' local insurance

regulation." *See id.* at 747.

In *Pilot Life*, the Court also relied on the totality of ERISA's structure and language to support its finding that ERISA's civil enforcement provisions are exclusive. This finding is in conflict with the Court's more recent ERISA rulings. As the Court has recognized repeatedly, "[a]s in any case of statutory construction, our analysis begins with the language of the statute . . . And where the statutory language provides a clear answer, it ends there as well." *See Harris Trust & Savings v. Salomon Smith Barney, Inc.*, 530 U.S. 238, 254 (2000) (quoting *Hughes Aircraft Co. v. Jacobson*, 525 U.S. 432, 438 (1999)). The Court's interpretation of ERISA's pre-emption clause in *Pilot Life* departs from the statutory text. Indeed, if ERISA is as "comprehensive and reticulated" as the Court has stated, *id.* at 2187, Congress could have easily stated that the civil enforcement provisions are exclusive. *See Inter-Modal Rail Employees Ass'n v. Atchison, Topeka & Santa Fe Railway Co.*, 520 U.S. 510, 515 (1997) ("Had Congress intended . . . it could have easily" done so.) It did not.

Instead, reliance on the structure and language of ERISA should have led the Court in *Pilot Life* to a conclusion the opposite of the one it drew. *Cipollone* would counsel that it would be rare for other provisions of a federal law to overcome an explicit pre-emption provision. 505 U.S. at 516, Significantly, the Court ignored the established rule that a statute, if possible, should be construed in such a fashion that every word or, in this case, every section has some operative effect so that no part will be rendered superfluous. *Mertens*, 508 U.S. at 257-58 (citing *United States v. Nordic Village, Inc.*, 503 U.S. 30, 36 (1992); *Moskal v. United States*, 498 U.S. 103, 109-10 (1990)). Its analysis in *Pilot Life* of the relationship between the civil enforcement provisions and saving clause ignores explicit Congressional intent and renders the saving clause, at least in some instances, superfluous.

Quite simply, the language and structure of ERISA applies to employee benefit plans, not HMOs as insurers. The balance struck in ERISA was to protect pension plans and

their financial integrity to ensure that plan participants received the benefits they were promised. It was not to allow insurers to escape state regulation and oversight. The inference that Congress, by its scheme of limited remedies, meant those remedies to be exclusive must give way to the express and unambiguous statutory language in the saving clause that states have the right to provide insureds with a broad range of remedies against insurers. Even if § 4-10 of the Illinois HMO Act is considered an additional remedy or civil enforcement provision, it should be saved as a state law regulating the business of insurance and therefore not pre-empted.

CONCLUSION

For the above reasons, *amici* urge the Court to affirm the Seventh Circuit's decision that ERISA does not pre-empt § 4-10 of the Illinois Health Maintenance Organization Act.

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